December 18, 2024 Council

Wednesday, December 18, 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	
0 min	8:10 am	2.	Agenda – Approval			
0 min	8:10 am	3.	Call for Conflict of Interest			3
5 min	8:10 am	4.	Consent Agenda i. Council Meeting Minutes September 25, 2024 ii. Council Policy – Approved Specialty Fields of Practice Classes iii. Council Policy – Certificate of Practice iv. Council Policy – Process for Appealing Investigation Committee Decisions v. Council Policy – Specialist Register	For Approval	Dr. Shenouda	4
15 min	8:15 am	5.	Consultation Approval – Practice Direction for Professional Practice Inactivity	For Approval	Dr. Shenouda/ Mr. Triggs	66
15 min	8:30 am	6.	President-Elect Nomination	For Discussion/ Approval	Dr. Shenouda	79
20 min	8:45 am	7.	Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism	For Discussion/ Approval	Dr. Shenouda/ Dr. Monkman/ Mr. Triggs	81
30 min	9:15 am	8.	Mandatory Training - TRC	For Discussion/ Approval	Dr. Shenouda/ Dr. Monkman/ Mr. Triggs	166
10 min	9:25 am	9.	Restorative Practices Program	For Information	Dr. Monkman/ Dr. Mihalchuk/ Mr. Triggs	186
20 min	9:45 am	10.	M3P – Codeine	For Discussion/ Approval	Dr. Shenouda/ Mr. Triggs/ Dr. Reinecke	187
10 min	9:55 am	11.	IMG Working Group Update	For Information	Dr. Shenouda/ Mr. de Jong	203
20 min	10:15 am		--Break--			

Time		Item		Action		Page #
5 min	10:35 am	12.	Registrar and CEO Report • Performance Metrics Update • Operational Report	For Information	Dr. Mihalchuk	205
10 min	10:40 am	13.	Committee Reports (questions taken) • Executive Committee • Finance, Audit & Risk Management Committee • Investigation Committee • Complaints Committee • Program Review Committee • Board of Assessors • Central Standards Committee	For Information	Dr. Shenouda/ Committee Chairs	223
60 min	10:50 am	14.	In Camera	For Discussion		
	11:50 am	15.	Review of Self-Evaluation of Governance Process-survey via email		Dr. Shenouda	
3 hours 50 minutes			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
DECEMBER 18, 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.

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

i. Council Meeting Minutes September 25, 2024

ii. Council Policy – Approved Specialty Fields of Practice Classes

iii. Council Policy – Certificate of Practice

iv. Council Policy – Process for Appealing Investigation Committee Decisions

v. Council Policy – Specialist Register

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 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 3Y7
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 September 25, 2024, at the CPSM Office with an option to join virtually via Zoom.

1. CALL TO ORDER

The meeting was called to order at 08:06 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 - Virtually
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Chaitasi Intwala, Winnipeg -Virtually/In-person
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 -Virtually/In-person
Dr. Peter Nickerson, Winnipeg - Virtually
Ms. Leanne Penny, Public Councillor - Virtually
Dr. Nader Shenouda, Oakbank
Dr. Alewyn Vorster, Treherne

MEMBERS:
Ms. Clara Weiss, Clinical Assistant
Ms. Kali Braun, Physician Assistant

STAFF:
Dr. Ainslie Mihalchuk, Registrar & CEO
Dr. Guillaume Poliquin, Assistant Registrar
Mr. Mike Triggs, General Counsel - Virtually
Mr. Paul Penner, Chief Operating Officer
Dr. Sonja Bruin, Interim Director Quality
Mr. Jeremy de Jong, Interim Director Registration
Ms. Barbie Rodrigues, Senior Executive Assistant
Ms. Karen Sorenson, Executive Assistant
Ms. Wendy Elias-Gagnon, Communications Officer
Dr. Marilyn Singer, Medical Consultant - Virtually

ABSENT:
Dr. Caroline Corbett, Winnipeg, no regrets received

SICK:
Dr. Charles Penner, Brandon, regrets sent to Dr. Shenouda

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. RIZWAN MANJI, SECONDED BY MS. MARVELLE MCPHERSON:
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 provided an overview of how the Consent Agenda is used. Dr. Shenouda asked if any Councillors wanted to discuss any of the consent agenda items. As there were none.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. RIZWAN MANJI:
CARRIED

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

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 Amendment to Governance Policy
vii. Practice Direction Qualifications and Registration

5. ACCREDITED FACILITIES BYLAW AMEDMENTS

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY RIZWAN MANJI:
CARRIED:

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

6. TRC ADVISORY CIRCLE UPDATE – FOR DISCUSSION

The matter was deferred until Dr. Monkman arrived in person. Agenda Item # 10 was addressed as the next matter.

Dr. Monkman presented the Briefing Note updating Council on activities related to the implementation of the 7 recommendations of the TRC Advisory Circle. Dr. Monkman expressed how deeply personal and proud she is of the work completed so far and her appreciation of the support provided by CPSM. Indigenous Peoples in Manitoba is continuing to face many health gaps, working on the educational piece will help us all grow and learn and be leaders in the country.

Dr. Shenouda thanked Dr. Monkman for her supportive role as well as her leadership in bringing forward the implementation of 7 recommendations of the TRC Advisory Circle.

7. STANDARD OF PRACTICE – PRACTICING MEDICNE TO PREVENT ANTI-INDIGENOUS PRACISIM

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. JENNIFER MCNAUGHT:
CARRIED:

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.

8. RESTORATIVE PRACTICES PROGRAM

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY MR. ALLEN FINEBLIT:
CARRIED:

Council authorizes 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.

Dr. Shenouda thanked Ms. Karen Sorenson for the continuous hard work as administrative support for the TRC Advisory Circle and IMG Working Group and Mr. Mike Triggs for his role.

9. BREAK @ 9:41 to 10:03 AM

10. PRACTICE DIRECTION – PRACTICE SUPERVISION REQUIREMENTS FOR CLINICAL AND PHYSICIAN ASSISTANTS AND PHYSICIAN ASSISTANT STUDENTS CONTEXTUAL INFORMATION & RESOURCES DOCUMENT – FOR INFORMATION

As noted in Agenda Item # 6, this matter was addressed at that point in the meeting.
Dr. Shenouda provided a background overview. CPSM and Doctors Manitoba engaged in further discussion after the March CPSM Council and agreed upon acceptable language for a revised concise Contextual Information and Resources document as provided as Appendix A.

11. IMG WORKING GROUP – FOR INFORMATION

Dr. Shenouda and Mr. Jeremy de Jong presented the update on the activities of the IMG Working Group. Updates will continue to be provided to Council.

12. NATIONAL REGISTERY – MCC – FOR INFORMATION

Dr. Mihalchuk who had returned from the Medical Council of Canada (MCC) Annual General and Data Governance Advisory Committee (DGAC) meetings held on September 23rd and 24th provided an update on the status of the National Registry project.

Updates will continue to Council as applicable, next DGAC meeting is December 4, 2024.

13. PERFORMANCE METRICS – FOR INFORMATION

Mr. Paul Penner presented the Performance Metrics update.

In the coming months, further review will be completed to determine if the same metrics will continue or if new ones will be implemented. Complaints & Investigations, Registration, Finance, Information Technology, Human Resources and Communications will work to refine their performance measures.

As of March 2025, scorecards will be distributed quarterly to Council as part of the Operational Report.

14. REGISTRAR/CEO REPORT AND OPERATIONAL REPORT – FOR INFORMATION

Dr. Mihalchuk presented the Council with the two reports outlining the matters currently being addressed at CPSM.

15. 2023/24 ANNUAL REPORT – FOR INFORMATION

Printed copies of the Annual Report were made available to Council members. The Annual Report is to remain confidential until posted on the CPSM website. Ms. Rodrigues will advise Council when that has occurred via email.

16. COMMITTEE REPORTS – FOR INFORMATON

The following Reports were presented to Council for information:

- Executive Committee
- Audit & Risk Management Committee
- Program Review Committee
- Complaints Committee
- Investigation Committee
- Standards Committee
- Board of Assessors

17. IN CAMERA SESSION

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

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

_____

Dr. N. Shenouda, President

_____

Dr. A. Mihalchuk, Registrar

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **New Council Policy for Registration Assessment Candidate Specialty Practice Classes, and Provisional Non-Practicing Classes.**

BACKGROUND:

A review of the Policies of Council, Policies of the Registrar, 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, updated wording and organization. Limited substantive changes are being made to existing requirements.

CURRENT REQUIREMENTS:

Currently, the subject matter of the new draft Policy found in sections **2.2.2.** and **2.15** of the Practice Direction - Qualifications and Registration. A consequential amendment to repeal these sections will be required if the Policy is approved. A "red-lined" copy of the amended Practice Direction is attached as *Appendix B.* ***** (note "red-lined" amendments to ***Consent Agenda item 4. ii (4.3.1)*** are also included as part of the agenda package). *****

PROPOSED CHANGES:

The new draft Policy is attached as *Appendix A*. The document adds explanatory notes and brings together various requirements for provisional registration into one document.

One substantive change is that the draft Policy removes the requirement for Council to approve all new fields that the Manitoba Faculty[1] can assess through its PRA program.

The current practice is for the Manitoba Faculty to request approval from Council for each new field of practice that they can assess through IMG Program. To date, all requests from the IMG Program have been approved with limited review. This is based on the relationship of trust between CPSM and the IMG Program.

[1] The *CPSM General Regulation* defines "Manitoba faculty" as the Max Rady College of Medicine in the Rady Faculty of Health Sciences at the University of Manitoba. («faculté du Manitoba»).

Section 2.2.1. of the new Policy reads:

> *Approved fields of specialty practice for the purposes of subsection **3.38(b)** of the CPSM General Regulation are those fields approved by the Manitoba Faculty's IMG Program, with notice to CPSM. Approved fields are listed on the attached 'List of Approved Fields of Specialty Practice for Assessment', which is updated by the Manitoba Faculty from time to time and incorporated by reference into this Policy.*

This section will replace section **2.15** of the Practice Direction, and the Manitoba Faculty to update the list without Council's intervention. The list must be provided to CPSM, and updates will be incorporated by reference.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the attached Council Policy – Registration Assessment Candidate Specialty Practice Classes to be effective immediately.
>
> Sections **2.2.2** and **2.15** of the Qualifications and Registration Practice Direction is repealed.

COUNCIL POLICY - DRAFT

Provisional Speciality Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes

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

DRAFT

[This Policy is intended to replace sections 2.2.2. and 2.15 of the current Registration and Qualifications Practice Direction]

Contents

PREAMBLE:

This Policy relates to registration in the following classes:

- provisional (specialty practice-limited),
- assessment candidate (specialty practice), and
- provisional (non-practicing).

Specific provisions of the *CPSM General Regulation* that apply to each of the above classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements that have been approved by Council.

This Policy addresses what is required for a certificate of registration. It does not deal with the requirements for certificates of practice, which are described at Part 4 of the *CPSM General Regulation*.[1]

1. Provisional (specialty practice-limited) class

1.1. Purpose and overview

The provisional (specialty practice-limited) class allows for the registration of specialist physicians who do not meet all Specific Requirements for full licensure (i.e., Royal College[2] certification, successful completion of MPAP, SEAP affiliate status, or under CFTA). This applies to many internationally trained physicians, and Canadian trained physicians who have not obtained Royal College certification.

Applicants for registration in the provisional (specialty practice-limited) class must satisfy the following requirements from the *CPSM General Regulation*:[3, 4]

- the Common Requirements for all registrants of CPSM at s. 3.2,
- the Non-Exemptible Requirements for all Regulated Registrants at s. 3.7, and
- the Specific Requirements for this class at s. 3.16, including academic requirements.

Applicants must commit to work toward achieving the requirements for full licensure within five (5) years of initial registration in the provisional class.[5] Additional requirements, including terms and conditions of registration and practice supervision, are imposed.

[1] Part 4 of the *CPSM General Regulation* establishes the requirements for issuing a certificate of practice. Of note, s. 4.1 states, "*A certificate of registration does not entitle a member to practise medicine. To do so, a member must also hold a certificate of practice. ...*"
[2] Royal College of Physicians and Surgeons of Canada.
[3] RHPA at s. 32(1).
[4] Subsection 3.2(1) of the *CPSM General Regulation* at point 8.
[5] Royal College, MPAP, SEAP.

Unless exempt, applicants must have satisfactorily completed an Approved Assessment to be eligible for registration in the provisional (specialty practice-limited) class. Exemptions are described below. Approved assessments may be completed while registered in the assessment candidate (specialty practice) class (which is also described in this Policy).

1.2. Specific Requirements under the *CPSM General Regulation*

1.2.1. Specific Requirements for provisional (specialty practice-limited) class are set out at section 3.16 of the *CPSM General Regulation*:

3.16(1) An applicant for registration as a provisional (specialty practice-limited) member must

(a) establish that he or she holds

(i) a medical degree granted from a nationally approved faculty of medicine,[6] or

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

(b) establish that he or she meets one of the following criteria:

(i) he or she

(A) holds the qualifications to engage independently in the practice of medicine in a specialty field of practice in a jurisdiction outside Canada in which the applicant has trained, and

(B) has satisfactorily completed post-graduate clinical training in the specialty that took place in one or more facilities that provide health care and are recognized by a national post-graduate training authority, was accredited by a national post-graduate training authority, and is approved by the registrar;

(ii) he or she holds Royal College certification or is confirmed by the Royal College to be eligible for Royal College certification,

(iii) he or she holds Member Board certification or is confirmed by a Member Board to be eligible for board certification,[7]

(iv) he or she holds certification in a specialty field from the Collège des médecins du Québec;

(c) establish that he or she holds a certificate issued by the minister stating that the applicant is required to provide medical services in a specified geographical area or practice setting;

[6] Defined at s. 1.4. of the *CPSM General Regulation*.

[7] Per s. 1.4 of the CPSM General Regulation, "Member Board" means a Member Board of the American Board of Medical Specialties.

(d) if applicable, establish that he or she has engaged in the professional practice that he or she intends to practise in Manitoba within the approved time period;[8]

(e) if applicable, provide a description of the continuing professional development activities that the applicant was required to complete as a condition of authorization to practise medicine in any jurisdiction in Canada in the three years immediately preceding the application and indicate how he or she met those requirements;

(f) establish that he or she has entered into a satisfactory arrangement with a practice supervisor;

(g) subject to subsection (2), establish that he or she has

(i) satisfactorily completed an approved assessment in his or her specialty field of practice, and

(ii) entered into a satisfactory arrangement with a practice mentor;

(h) [repealed] M.R. 171/2022.

1.3. Currency in practice requirement (ss. 3.16(d))

1.3.1. Applicants who do not meet the currency in practice requirement at subsection 3.16(d) of the *CPSM General Regulation* are not eligible for provisional (specialty practice-limited) class registration. They may be eligible for registration in the assessment candidate (re-entry to practice) class for the purpose of undergoing an assessment (see section 3.44 of the *CPSM General Regulation*).

1.3.1.1. The currency in practice requirement is further described in CPSM's Practice Direction for Professional Practice and Inactivity.

1.3.1.2. This assessment candidate (re-entry to practice) class is further described in CPSM's Council Policy for the Assessment Candidate (Re-Entry to Practice) Class.[9]

1.4. Assessment requirement (ss. 3.16(1)(g)(i)) and exemptions

Approved Assessments

1.4.1. Subsection 3.16(1)(g)(i) of the *CPSM General Regulation* states that, subject to available exemptions (see below), applicants for registration in the provisional (speciality practice-limited) class are required to establish that they have satisfactorily completed an Approved Assessment in their

[8] The approved period is set out in CPSM Practice Direction for Professional Practice and Inactivity.

[9] If an applicant does not meet both the currency in practice requirement (ss. 3.16(1)(d)) and the approved assessment requirement (ss. 3.16(1)(g)(i)), then assessment candidate registration under section 3.38 and 3.44 may be blended if all other applicable registration requirements are met.

specialty field of practice. Specialty practice assessments that have been approved by Council are as follows:[10]

1.4.1.1. Participation in the Practice Ready Assessment - Specialty Practice ("PRA-SP") limited to those specialty programs offered by the Manitoba Faculty.[11]

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

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

1.4.1.4. An assessment conducted elsewhere in Canada certified by the Dean of the Manitoba Faculty 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 Manitoba Faculty.

1.4.1.5. Satisfactory completion of a program accredited by the Royal College in a Canadian university teaching hospital.

1.4.1.6. Limited to those candidates who have completed fellowship training at the Manitoba Faculty, certification by the Program Director that the candidate:

1. successfully completed an equivalent assessment in respect to specified components of the PRA-SP as part of the fellowship, and
2. participated in the remaining components of the PRA-SP not covered by the fellowship.

1.4.1.7. 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.

Exemptions to having to undergo an Approved Assessment

1.4.2. Subsection 3.16(2) provides exemptions to having to undergo an Approved Assessment:

3.16(2) An applicant is exempt from the requirements in clauses (1)(g) (assessment and practice mentor) if the applicant establishes that one of the following criteria is met:

[10] In approving assessments, the main issue is ensuring confirmation of competency. A secondary goal is ensuring equivalency for what is required to obtain Royal College certification eligibility. The goal should be for the candidate to establish Royal College eligibility through the assessment process.

[11] Formerly known as the Non-Registered Specialist Assessment Programs.

(a) he or she

(i) was not a member on the day he or she applies for registration in this class but

(A) was previously registered as a provisional (specialty practice-limited) or provisional (academic — s. 181 faculty) member in good standing, or

(B) was previously conditionally registered in a specialty field under the former Act or was previously registered in a specialty field under section 64 of that Act,

(ii) has either satisfactorily completed an approved specialty practice assessment in the intended specialty field of practice or was exempt under the former Act from such a requirement while he or she was previously registered under the former Act, and

(iii) has the training and experience necessary to competently engage in his or her professional practice within the intended specialty field of practice;

(b) he or she holds Royal College certification or provides written confirmation from the Royal College that he or she is eligible for certification unless the eligibility has been or will be obtained through the practice eligibility route;[12]

(b.1) he or she

(i) holds affiliate status with the Royal College in a subspecialty,

(ii) successfully completed a Royal College subspecialty examination through the Royal College — Subspecialist Examination Affiliate Program, and

(iii) has been required by the registrar to undergo an approved period of supervised practice;

(c) he or she holds Member Board certification and has satisfactorily completed a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (USA);

(d) he or she holds certification from the Collège des médecins du Québec;

(e) in any other case, he or she meets the approved criteria for an exemption.

Candidates who have not completed an Approved Assessment

1.4.3. Candidates who do not establish that they have satisfactorily completed an Approved Assessment, or are not otherwise exempt from this requirement, are not eligible for provisional (specialty practice-limited) class registration. However, they may be eligible for registration in the assessment candidate

[12] The rationale for this is that eligibility through the Practice Eligibility Route may be obtained without experience in the Canadian health care system.

(specialty practice) class for the purpose of undergoing an Approved Assessment (see section 3.38 of the *CPSM General Regulation*).

1.4.4. For registration in the assessment candidate (specialty practice) class, applicants must meet all other requirements for registration in the provisional (specialty practice-limited) class, but for subsection 3.16(1)(g), and must establish that they:

1.4.4.1. intend to practice in a specialty field of practice approved for the assessment candidate (specialty practice) class,

1.4.4.2. have been accepted into an Approved Assessment in a specialty field of practice, and

1.4.4.3. have an employment offer to engage in their professional practice in a specific geographical area or practice setting that is approved by the Minister.

1.4.5. The assessment candidate (specialty practice) class is further described below.

1.5. Terms and conditions

1.5.1. Provisional (specialty practice-limited) class registration is time limited and subject to restrictions imposed by the Minister's certificate. Section 3.17 of the *CPSM General Regulation* provides:

> *3.17(1) A person may be registered as a provisional (specialty practice-limited) member for a time period of not more than five years, which may be extended in accordance with sections 3.71 to 3.73.*
>
> *3.17(2) A person may be registered as a provisional (specialty practice-limited) member to practise in a specific geographical area or practice setting as specified in the person's ministerial certificate.*

1.5.2. Provisional (specialty practice-limited) class registrants must be supervised in respect to their professional practice and must work toward full registration:

> *3.18(1) As a condition of registration, a provisional (specialty practice-limited) member must be working towards meeting the requirements to be registered as a full (practising) member by either*
>
> *(a) obtaining registration in the Canadian Medical Register as a holder of the LMCC and Royal College certification in a specialty field of practice; or*

> *(b) obtaining the designation of "successful in the MPAP" in the area in which he or she is assessed.*
>
> *3.18(2) As a condition of registration, a provisional (specialty practice-limited) member must have a practice supervisor.*

1.5.3. Practice supervision must accord with the requirements of the Council Policy for Supervision of Provisional Registrants.

1.6. Extension of provisional registration

1.6.1. Under section 3.71 of the *CPSM General Regulation*, the Registrar may extend the usual maximum five (5) year period of registration for up to an additional twelve (12) months, subject to any conditions the Registrar considers advisable. The registrant must apply in writing for an extension before their five (5) years expires and set out the reasons for the extension request.

1.6.2. In accordance with section 3.71 of the *CPSM General Regulation*, the extension may be granted if the Registrar determines that the member requires the extension due to an extended absence from professional practice due to a medical condition or for a statutory or approved leave. In any application for an extension, the onus is on the registrant to demonstrate that the extension should be granted, and the following conditions must be met:

1.6.2.1. The registrant must be eligible to receive a satisfactory certificate of good standing.

1.6.2.2. If applicable, the registrant must undertake to attend the earliest dates of the examination sittings and to cease registration if the physician is unsuccessful in the examinations.

1.6.3. Sections 3.72 and 3.73 CPSM of the *CPSM General Regulation* require that the Registrar provide written reasons for their approval or refusal of the extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

1.7. Conversion to another class

1.7.1. Registration in the provisional (specialty practice-limited) class is limited to a five (5) year period, plus any extension granted by the Registrar. By the end of that period, to maintain registration, the member must covert to another class for which they are eligible, for example the provisional (MPAP) class or the full (practicing) class. Members in the provisional (specialty practice-

limited) class may also be converted to the provisional (non-practicing) class in certain specified circumstances. Conversion is governed by sections 3.74 and 3.75 of the *CPSM General Regulation*, which provide:

> *3.74(1) If*
>
> *…(a) a provisional (specialty practice-limited) member in good standing;*
>
> *…*
>
> *ceases to have a practice supervisor, the registrar may change the member's registration to provisional (non-practising) membership for a period of not more than 30 days from the date the member ceases to have a practice supervisor.*
>
> *3.74(2) If the member enters into a subsequent satisfactory arrangement with a practice supervisor before the 30-day period expires, the registrar may change the member's registration to the applicable class listed in subsection (1).*
>
> *3.75 Upon receiving a designation of "successful in the MPAP" or otherwise completing the requirements for full (practising) membership under section 3.8, a member's registration in*
>
> *(a) the provisional (specialty practice-limited) class;*
>
> *…*
>
> *may be changed by the registrar to the full (practising) class.*

1.7.2. If the 30-day period contemplated under section 3.74 of the *CPSM General Regulation* expires without the registrant identifying a new supervisor, then the registrant's registration is cancelled as they no longer meet registration requirements.

1.8. Cancellation

1.8.1. Section 3.84 of the *CPSM General Regulation* provides as follows:

> *3.84(1) The registration of a provisional (specialty practice-limited) member … is cancelled on the earliest occurrence of the following:*
>
> *(a) the ministerial certificate is revoked or lapses;*
>
> *(b) the member is no longer eligible for the Medical Council of Canada examination for cause;*
>
> *(c) the member's certification by the Royal College, American Board of Medical Specialties, or CFPC, as the case may be, is revoked for cause;*
>
> *(d) the specified or extended membership period ends;*

(e) the member receives the designation of "unsuccessful in the MPAP";
(f) the member ceases to practise in Manitoba.

3.84(2) A person whose registration is cancelled under clause (1)(d) or (e) may apply for registration only as a regulated associate member in one of the following classes:
(a) educational (medical student);
(b) educational (physician assistant);
(c) educational (resident);
(d) clinical assistant (full)

3.84(3) To avoid doubt, a person whose registration is cancelled under clause (1)(d) or (e) is not permitted to apply for any class of regulated or regulated associate membership other than the ones listed in clauses (2)(a) to (d).

2. Assessment candidate (specialty practice) class

The assessment candidate (specialty practice) class is intended for candidates who do not meet all Specific Requirements for registration in the provisional (specialty practice-limited) class. It is to allow for the candidate to undergo an Approved Assessment in a specialty field of practice.

The assessment candidate (specialty practice) class of registration is not available to all specialty fields. Eligibility is restricted to those who intend to practice in a specialty that Council has determined is eligible for the class.

To be considered for registration, applicants must establish they have been accepted into an Approved Assessment and that they have an employment offer to engage in their professional practice in a specific geographical area or practice setting that is approved by the Minister.

2.1. Specific requirements under the *CPSM General Regulation*

2.1.1. Specific requirements for the assessment candidate (specialty practice) class are set out at section 3.38 of the *CPSM General Regulation*:

3.38 The registrar may register an applicant in the assessment candidate (specialty practice) class if the applicant
(a) establishes that he or she meets the requirements for registration as a provisional (specialty practice-limited) member in subsection 3.16(1) other than the requirements to
(i) enter into a satisfactory arrangement with a practice supervisor under clause 3.16(1)(f), and

(ii) complete an approved assessment in his or her specialty field of practice and enter into a satisfactory arrangement with a practice mentor under clause 3.16(1)(g);

(b) establishes that he or she intends to practise in a specialty field of practice approved for this membership class;

(c) establishes that he or she has been accepted into an approved assessment in a specialty field of practice; and

(d) establishes that he or she has an employment offer to engage in his or her professional practice in a specific geographical area or practice setting that is approved by the minister.

2.2. Specialty fields of practice approved for this class

2.2.1. Approved fields of specialty practice for the purposes of subsection 3.38(b) of the *CPSM General Regulation* are those fields approved by the Manitoba Faculty's IMG Program, with notice to CPSM. Approved fields are listed on the attached 'List of Approved Fields of Specialty Practice for Assessment', which is updated by the Manitoba Faculty from time to time and incorporated by reference into this Policy.[13]

2.3. Accepted into an approved assessment

2.3.1. Council has approved the Practice Readiness Assessment - Specialty Practice ("PRA-SP") offered through the Manitoba Faculty's IMG Program. This is limited to those specialty programs offered by the PRA-SP program.

2.3.2. CPSM will not accept an application for registration in the assessment candidate (specialty practice) class unless it is supported by a letter of eligibility for the PRA-SP from the IMG Program.

2.4. Employment offer

2.4.1. CPSM will not accept an application for registration in the assessment candidate (specialty practice) class unless it is supported by an employment offer to engage in professional practice in a specific geographical area or practice setting that is approved by the Minister.

[13] Where there is uncertainty as to whether an applicant can be assessed in a particular specialty field of practice, the Royal College of Physicians and Surgeons of Canada or the Manitoba Faculty may be consulted. The goal is to achieve equivalence for Royal College eligibility. As such, whether training would be recognized by the Royal College is the main question.

2.5. Time limited registration

2.5.1. Registration in this class is time limited. Section 3.39 of the *CPSM General Regulation* provides:

> *3.39(1) A person may be registered as an assessment candidate (specialty practice) member for a time period of up to 12 months, which may be extended in accordance with sections 3.71 to 3.73.*
>
> *3.39(2) The time period described in subsection (1) does not include the time period for the orientation program referred to in section 3.40.*

2.5.2. Under section 3.71 of the *CPSM General Regulation*, the Registrar may extend the usual twelve (12) month period of registration for up to an additional twelve (12) months, subject to any conditions that the Registrar considers advisable. The registrant must apply in writing for an extension before their registration period expires and set out the reasons for the extension request.

2.5.3. In accordance with section 3.71 of the *CPSM General Regulation*, the extension may be granted if the Registrar determines that the member requires the extension due to an extended absence from professional practice due to a medical condition or for a statutory or approved leave. In any application for an extension, the onus is on the registrant to demonstrate that the extension should be granted, and the following conditions must be met:

2.5.3.1. The registrant must be eligible to receive a satisfactory certificate of good standing.

2.5.3.2. The registrant must undertake to complete the assessment promptly.

2.5.4. Sections 3.72 and 3.73 of the *CPSM General Regulation* require that the Registrar provide written reasons for their approval or refusal of the extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

2.6. Terms and conditions

2.6.1. Registration in this class is restricted to a specific practice setting and professional practice and may be subject to completing an orientation. Subsections 3.39(3) and 3.40 of the *CPSM General Regulation* provide:

3.39(3) A person may be registered as an assessment candidate (specialty practice) member to practise in a specific practice setting.

3.40 As a condition of registration, the registrar may require that an assessment candidate (specialty practice) member complete an orientation program within a time period approved in accordance with a national standard.

2.7. Conversion to provisional registration

2.7.1. Subsection 3.77(1) of the *CPSM General Regulation* provides:

3.77(1) Upon successful completion of the approved specialty practice assessment, the registration of an assessment candidate (specialty practice) may be changed by the registrar to provisional (specialty practice-limited) membership.

2.8. Cancellation

2.8.1. Assessment candidate (specialty practice) registration is cancelled in the following circumstances:

3.91 The registration of an assessment candidate (specialty practice) member or assessment candidate (family practice) member is cancelled on the earliest occurrence of the following:

(a) the specified or extended membership period ends;
(b) the member completes his or her assessment and the registrar receives the assessment results and changes his or her membership class as provided for in subsection 3.77(1) or (2);
(c) the member fails the assessment or fails to complete it.

3. Provisional (non-practicing) class

3.1. The provisional (non-practising) class is intended for provisional registrants who take a leave of absence with the intent to return to practice. For example, this may occur due to a gap in supervision, or a medical leave of absence.

3.2. To convert to the provisional (non-practising) class, the registrant must meet the specific requirements set out at subsection 3.34 of the *CPSM General Regulation*:

3.34(1) An applicant for registration as a provisional (non-practising) member must establish that he or she was registered in good standing in one of the following membership classes immediately before applying for non-practising membership:

(a) provisional (academic — s. 181 faculty);
(b) provisional (specialty practice-limited);
(c) provisional (family practice-limited);
(d) provisional (public health officer).

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

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

3.4. Conversion to the provisional (non-practising) class will be the usual default for registrants who no longer hold a valid certificate of practice (e.g., if it was not renewed or their Practice Supervisor resigns).

3.5. The maximum registration period for registrants who convert from the provisional (specialty practice-limited) class to the provisional (non-practising) class is indicated at section 3.35 of the *CPSM General Regulation*:

The maximum time period for provisional (non-practising) membership for a member who was previously registered as a provisional (specialty practice-limited) member or provisional (family practice-limited) member is the remaining time period that he or she had under subsection 3.17(1) or 3.20(1), as the case may be, with any extensions approved before he or she was registered under this section.

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 – REPEALED DATE – SEE POLICY – NAME

~~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. REPEALED DATE – See Policy – NAME Specialty Practice Assessments approved for the purposes of CPSM General Regulation s. 3.16 (1) (g) (i):~~

~~2.2.3. Satisfactory completion of a program accredited by the Royal College of Physicians and Surgeons of Canada in a Canadian university teaching hospital.~~

~~2.2.4. 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.~~

~~2.2.5. 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.~~

~~2.2.6. Limited to those candidates who have completed fellowship at the Rady Faculty of Health Sciences, Max Rady College of Medicine:~~

~~2.2.7. Certification by the Program Director that in the fellowship the candidate successfully completed an equivalent assessment to specified components of the PRA-SP, and~~

~~2.2.8. Participation in the remaining components of the PRA-SP not covered by the fellowship, as certified by the Program Director.~~

~~2.2.9. The Western Alliance for Assessment of International Physicians, limited to general surgery or internal medicine candidates.~~

~~2.2.10. The Canadian practice ready assessment for specialty practice in psychiatry or internal medicine.~~

~~2.2.11. 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.~~

~~2.2.12.~~

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. REPEALED – DATE – See Policy NAME

~~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~~

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

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

2.23. REPEALED – SEPTEMBER 25, 2024 – See Council Policy Certificate of Professional Conduct

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

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **New Council Policy for Certificates of Practice**

BACKGROUND:

A review of the Policies of Council, Policies of the Registrar, 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, updated wording and organization. Limited substantive changes are being made to existing requirements.

PROPOSED CHANGES:

The new draft Policy is attached as *Appendix A;* it will replace Part 1 of the current Qualifications and Registration Practice Direction. A "red-lined" copy of the current Qualifications and Registration Practice Direction is included as *Appendix B (**4.2.2**) to **Consent Agenda Item 4. ii***.

Changes are to add explanatory notes and references to the *CPSM General Regulation*. The Policy includes details about when a certificate of practice is required for administrative work, research, and teaching.

There are no significant changes in the new Policy.

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the attached Council Policy – Certificates of Practice to be effective immediately.
>
> Practice Direction – Qualifications and Registration Practice Part 1 is repealed.

COUNCIL POLICY - DRAFT

Certificates of Practice

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

DRAFT

[This is to replace Part 1 of the Qualifications and Registration Practice Direction]

Contents

1. Overview of registration and certificates of practice

All registrants of CPSM are issued a certificate of registration that indicates their class of registration. Depending on their registration class, and subject to the requirements of the *CPSM General Regulation*, registrants may then also be issued a certificate of practice.

Certificates of practice are essentially a license to practice. Only those registered with CPSM who hold a valid certificate of practice are authorized to practice medicine in Manitoba.[1, 2] Registrants in a non-practicing class are not issued a certificate of practice (e.g., retired registrants), and are not authorized to practice medicine.[3]

Registrants who hold a valid certificate of practice are permitted to perform the reserved acts listed at section 4 of the RHPA (e.g., diagnosing illness, prescribing, etc.), as long as they are safe and competent to perform them, and the reserved act or acts fall within the registrant's authorized scope of professional practice.[4]

2. Eligibility requirements

To be eligible for a certificate of practice, applicants must hold a certificate of registration with CPSM and must satisfy the following requirements from the *CPSM General Regulation*:[5]

- the Common Requirements at ss. 4.4(1)[6],
- the Non-Exemptible Requirements at ss. 4.4(2),
- must be legally entitled to work or study, as the case may be, in Canada (s. 4.13), and
- for physician or clinical assistant applicants, the Additional Requirements at s. 4.5.

When applying for a certificate of practice, including for a renewal, 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*.

---

[1] Section 54 of the RHPA and subsection 4.2(1) of the *CPSM General Regulation*.

[2] Practicing registrants of CPSM who hold a valid certificate of practice can incorporate their medicine practice and practice through the medical corporation. To do so, they must obtain a medical corporation permit in addition to their certificate of practice.

[3] Subsection 4.3(2) of the *CPSM General Regulation* states that, "*A certificate of practice may not be issued to a member who is registered in a non-practising or retired class.*"

[4] Manitoba is a defined scope of practice jurisdiction. For further information, see CPSM's Practice Direction for Professional Practice and Inactivity.

[5] Subsection 4.4(1) of the *CPSM General Regulation* at point 4.

[6] For Regulated Registrants, this includes meeting the requirements at s. 40 of the RHPA. For Regulated Associate Registrants, this includes meeting the requirements at s. 41 of the RHPA.

In most cases, certificates of registration and certificates of practice are issued simultaneously at the time of initial registration. Certificates of practice are issued for a prescribed period, after which they expire and must be renewed if the registrant wishes to continue in practice.

Note that CPSM's registration requirements are subject to CPSM's obligations under *The Labour Mobility Act.*

3. Certificates of practice and authorized scope of practice

Registrants who are issued a certificate of registration and a certificate of practice are permitted to practice medicine, but only as authorized by these certificates. A certificate of registration or a certificate of practice may be issued with terms and conditions or may have terms and conditions imposed after issuance.[7] Subsection 5(1) of the *Practice of Medicine Regulation* states:

> *Subject to the [RHPA] and the regulations and any conditions on the member's certificate of registration or certificate of practice, [they] may engage in the practice of medicine. But in doing so, the member may not act beyond the scope of practice of medicine.*

For further information, CPSM's Practice Direction for Professional Practice and Inactivity explains the scope of practice of medicine and sets out requirements for registrants regarding the need to recognize the limits of their skills and knowledge, and steps that need to be taken when expanding their professional practice to enter areas of inactivity (e.g., new areas of practice). The Practice Direction also includes special requirements for family physicians to include obstetrics or anaesthesia in their professional practice.

4. Content requirements for certificates of practice

Content requirements for certificates of practice are described at subsections 40(3) and 41(3) of the RHPA and include:

- the name of the registrant,
- class of registration,
- any conditions imposed on the registrant's practice,
- date of issue,
- a statement that the certificate of practice is issued pursuant to the RHPA, and
- the expiry date of the certificate.

5. Categories of certificates of practices issued by CPSM

5.1. CPSM will only issue a certificate of practice on a prescribed annual or monthly basis, unless the registration class otherwise indicates a defined period (e.g., the restricted purpose class).

[7] Subsection 40(2) of the RHPA and subsection 4.2(1) of the *CPSM General Regulation*.

5.1.1. In all cases, monthly certificates are issued on a monthly calendar basis (e.g., January 1 to January 31). Consecutive months may be combined.

5.1.2. The certificate of practice year for full, provisional, and assessment registrants is November 1 to October 31. For Educational it is July 1 to June 30.

5.1.3. Defined periods are set by the Registrar.

5.2. Applicable fees for certificates of practice are established in CPSM's Fee Bylaw.

5.3. The following tables indicate the available options for certificates of practice, depending upon class of registration.

Regulated Registrants

Certificate of Registration			Certificate of Practice options.
Register	Class		
Regulated Registrants	Full	Practicing	Annual or monthly
		Non-Practicing	Nil
	Provisional	Academic s. 181 faculty	Annual or monthly
		Academic Visiting professor	Defined period.
		Academic Post-certification trainee	Annual or monthly
		Specialty practice-limited	Annual or monthly
		Family practice-limited	Annual or monthly
		MPAP	Annual or monthly
		Restricted purpose	Defined period.
		Public health officer	Annual or monthly
		Temporary locum	Annual or monthly
		Transitional	Annual or monthly
		Non-practicing	Nil
	Retired (Physician)		Nil

Regulated Associate Registrants

Certificate of Registration			Certificate of Practice categories that may be issued by class.
Register	Class		
Regulated Associate Registrants	Assessment Candidate	Specialty Practice	Annual or monthly.
		Family Practice	Annual or monthly.
		Re-entry to Practice	Annual or monthly.
	Educational	Medical Student	Annual.
		Physician Assistant Student	Annual.
		Resident	Annual.
		Resident-limited	Annual or reduced (8 months or less).
		External or visiting student	Per 6-month period.
		Non-practicing	Nil.
	Physician Assistant	Full	Annual or monthly.
		Restricted purpose	Defined period.
		Academic- s. 181 faculty	Annual.
		Non-practicing	Nil
	Clinical Assistant	Full	Annual or monthly
		Non-practicing	Nil
	Retired	Physician assistant	Nil
		Clinical Assistant	Nil

6. Resident physicians

6.1. A resident who meets the qualifications for registration in the full (practicing) class of registration and who wishes to practice medicine outside of their approved residency program must apply for registration in the full (practicing) class and obtain an annual or monthly certificate of practice.

6.2. A resident physician who does not meet the qualifications for registration in the full (practicing) class and who wishes to practice medicine outside of their approved residency program may apply for registration in the resident-limited class for this purpose.

6.3. A registrant in the full (practicing) class who enters a residency program may apply to convert to the educational class and for a resident annual certificate of practice, if they are not planning to practice medicine outside of their approved residency program.

7. Expiry and cancellation of certificate of practice

Section 4.6 of the *CPSM General Regulation* deals with the expiry of certificates of practice:

> *4.6(1) Subject to subsection 46(3) of the [RHPA], a certificate of practice is valid from the date it is issued or renewed until the expiry date specified on the certificate.*
>
> *4.6(2) Despite subsection (1), a member's certificate of practice is no longer valid if*
>
> *(a) the member ceases to be registered in a class whose members are eligible for a certificate of practice;*
> *(b) the member's certificate of registration is cancelled or surrendered;*
> *(c) the member's certificate of practice is surrendered; or*
> *(d) the member ceases to be covered by the professional liability insurance or coverage required by subsection 4.12(1).*

Per section 4.9 of the *CPSM General Regulation*, a registrant's certificate of practice is cancelled when the registrant's registration is cancelled under the applicable provision in Part 3, Division 4 (Cancellation), of the *CPSM General Regulation*.

8. Renewal requirements

Section 4.7 of the *CPSM General Regulation* addresses renewal requirements:

> *4.7(1) To renew a certificate of practice, a member must*
>
> *(a) submit to the registrar items 1, 2 and 4 to 7 of subsection 4.4(1) and any other information required by the registrar; and*
> *(b) meet the continuing competency requirements under Part 10.*
>
> *4.7(2) If an applicant fails to meet the continuing competency requirements, the registrar may*

(a) renew the applicant's certificate of practice subject to any conditions that the standards committee or the registrar considers necessary or advisable; and
(b) require the applicant to successfully complete any examinations, tests, assessment, training or education that the registrar considers necessary to establish that the member is competent to engage in his or her professional practice.

9. Renewal of monthly certificate of practice

9.1. A Regulated Registrant renewing a monthly certificate of practice must pay the fee and inform CPSM of any changes in their information since the last renewal. All Regulated Registrants must meet annual renewal disclosure requirements.

9.2. Upon request, CPSM may issue monthly certificates of practice for consecutive months within the same certificate year. If a registrant with one or more full monthly certificates applies for an annual certificate within the same year, the fees paid for the monthly certificates will **NOT** be credited towards the annual fee.

9.3. Registrants choosing monthly or defined (short-term) practice certificates must ensure they renew and pay the fee before expiry, as **NO** renewal reminders will be issued. The registrant is responsible for maintaining a valid certificate of practice when practicing medicine in Manitoba.

10. Administrative Tasks, Research, and Teaching

Depending upon the circumstances, administrative work, research, and teaching activities may require a certificate of practice.

- Administrative tasks, including paperwork, may be clinical or non-clinical. Clinical activities are those which involve participating directly or indirectly in actual patient care. Administrative medicine often requires a certificate of practice.

- Clinical administrative work requires a valid certificate of practice. This includes important components of continuity of care such as documentation of care, preparing referrals, monitoring laboratory reports, diagnostic reports, and consultant reports, and oversight of prescribing. Monitoring reports may require follow-up directly with the patient to make sure they are aware and can seek care.

- Non-clinical administrative work includes billing, maintenance of patient records, monitoring phone, mail, email and other communications, and other day-to-day administrative and clerical tasks that are part of operating a medical practice. It can also include organizing coverage and alternate care arrangements. When this work relates to

the registrant's professional practice, numerous regulatory, ethical, and professional requirements apply, for example, managing conflicts, advertising requirements, and CPSM notice and reporting requirements. However, non-clinical administrative work can generally be done by a non-practicing registrant who does not hold a valid certificate of practice.

- Other non-clinical medical administrative work requiring a valid certificate of practice includes responsibilities for ensuring that a practice environment or setting is safe, appropriate, and sanitary respecting medical care delivered in the practice setting. In group settings, carrying out the responsibilities of the Medical Director, who must be a duly qualified medical practitioner in good standing, would be considered active practice necessitating a valid certificate of practice. This category would also include the practice of independent medical examiners, the Medical Director of a facility, public health physicians not directly involved in patient care, medical administrative aspects of the professional practice of the Dean of the Manitoba Faculty, and other similar practice areas.

- Clinical teaching and research that involves patient care requires a valid certificate of practice.

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

SUBJECT: New Council Policy – Appeals from Investigation Committee

ISSUE:

A streamlined and updated internal appeals policy is recommended to replace outdated and fragmented documentation currently governing the process for appeals from the Investigation Committee to the Executive Committee.

BACKGROUND:

Currently, there are two documents attached as *Appendix B* and *Appendix C* that address specific issues related to appeals of Investigation Committee decisions which results in a disjointed approach. The existing framework could benefit from greater clarity.

The proposed combined document offers greater detail and explanation about the appeals process and offers a more cohesive and transparent policy to guide appeal decisions. The draft Council Policy for appeals from the Investigation Committee is attached as *Appendix A*. Additions include greater explanation of standards of review that are consistent with legal precedent. Once approved a concise user summary will be developed for public use.

Objectives of the new policy:

- Consolidate the current Council Policy and Practice Direction into a single, comprehensive Council Policy.
- Greater clarity to the roles, responsibilities, and procedures for internal appeals to ensure transparency.
- Support streamlining the appeal process to reduce delays and administrative burden.
- Ensure a balanced process that upholds the principles of natural justice through additional information about standards of review.

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

NOM – New Council Policy for Appeals from Investigation Committee

Council approves the attached Council Policy – Appeals from Investigation Committee (*Appendix A*) to be effective immediately.

Practice Direction Appeals from Investigation Committee Decisions and Council Policy - Appeal Guidelines of IC Decisions (*Appendix B*) and are repealed.

The Practice Direction Appeals from Investigation Committee Decisions and Council Policy - Appeal Guidelines of IC Decisions.

COUNCIL POLICY - DRAFT

Appeals from Investigation Committee

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

DRAFT

Contents

1. Overview:

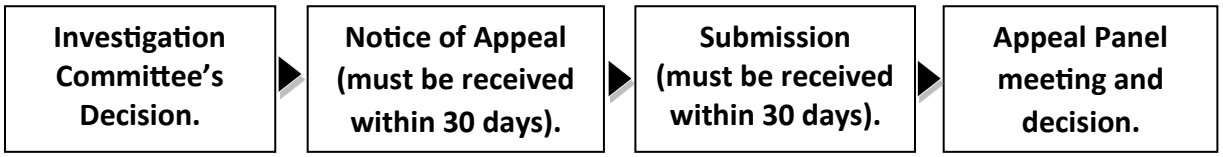
Under the *Regulated Health Professions Act* ("RHPA"), if a Complainant is not satisfied with a decision of the Investigation Committee, then they *may* have the right to appeal the decision to an Appeal Panel of the Executive Committee. Whether the Complainant has a right of appeal will depend upon the nature of the decision that was made by the Investigation Committee.

To make an appeal, the Complainant must send the Registrar a Notice of Appeal within 30 days of receiving the Investigation Committee's decision. Both the Complainant and the Investigated Registrant are given the opportunity to provide a written submission to the Appeal Panel.

Appeal Panels are typically made up of CPSM Council members. The Appeal Panel can dismiss the appeal, make any decision it believes ought to have been made by the Investigation Committee, or refer the matter back to the Investigation Committee for further investigation or consideration in accordance with any direction that the Appeal Panel may give.

Throughout the appeal process, the Complainant and the Investigated Registrant are entitled to have legal representation.

The following flow chart summarizes the process:



This Policy addresses procedural requirements and guiding principles for the Appeal Panel to follow in deciding appeals.

2. What is the purpose of the Appeal Panel?

The purpose of the Appeal Panel is to review the Investigation Committee's decision to determine if there are any significant errors or deficiencies. What the Appeal Panel can consider is limited based on law set by Canadian courts of appeal. The details of what the Appeal Panel can consider are explained in the section "Standards of Review".

It is important to understand that the Appeal Panel does not reconsider evidence and arguments to come to its own independent decision about the complaint that was made before the Investigation Committee. Its primary function is to correct unreasonable conclusions.

The Appeal Panel does not consider the same questions that were asked before the Investigation Committee. Applying the "Standards of Review" and considering the issues raised in the Notice of Appeal, the Appeal Panel decides if there is an error that affected the conclusion of the Investigation Committee's decision.

Guiding principles and considerations applicable to the Appeal Panel's review include:

- The Appeal Panel will not intervene merely because it disagrees with the decision of the Investigation Committee. It is possible for two people, acting reasonably, to come to two different conclusions. If the Investigation Committee decision is reasonable the Appeal Panel will not interfere with that decision merely because they would have decided the case differently.
- The key question for the Appeal Panel is whether the Investigation Committee's decision was based on errors of law, fact or principle, or is not reasonably sustainable.
- The focus of the appeal is not to re-examine the facts and evidence; rather, it is on the Investigation Committee's assessment of the facts and evidence, and its overall analysis and disposition of the matter.
- However, as this is an internal review process that serves CPSM's public interest mandate, the Appeal Panel will remain flexible and review the decision under appeal holistically, without a rigid focus on the stricture of the applicable standards of review.

3. What decisions can be appealed?

Section 102 of the RHPA limits the types of decisions that the Investigation Committee can make when it decides a complaint. A Complainant may appeal some, but not all, decisions made by the Investigation Committee depending on what action or actions the Committee decides to take.[1] The following table contains information about decisions that can and cannot be appealed.

Decisions that can be appealed.	**Decisions that cannot be appealed.**
• A direction that no further action is to be taken (ss. 102(1)(b)). • The acceptance of an undertaking from the Investigated Registrant. For example, for practice conditions, education, etc. (ss. 102(1)(f)). • Any other action the Investigation Committee considers appropriate under ss. 102(1)(g) of the RHPA. For example, criticism or advice.	• A referral to the Inquiry Committee (ss. 102(1)(a)) or censure (ss. 102(1)(d)). • Referral to mediation with the agreement of the Complainant and Investigated Registrant (ss. 102(1)(c)). • Acceptance of voluntary surrender of registration or license (ss. 102(1)(b)(e)). • Acceptance of an informal resolution under s. 95 of the RHPA.

[1] Subsection 108(1) of the RHPA states that "*The complainant may appeal to the council any decision made by the complaints investigation committee under clause 102(1)(b), (f) or (g).*"

When considering whether to bring an appeal, the Complainant should consider whether the Investigation Committee could make the decision that they would have liked it to make. If the Investigation Committee cannot make that decision, then the Appeal Panel also has no authority to make that decision.

4. Who decides appeals from decisions of the Investigation Committee?

Under the RHPA, appeals from decisions of the Investigation Committee are made to CPSM's Council. The Council has delegated authority to hear appeals to the Executive Committee.[2]

Appeals are ordinarily decided by a three-person panel of the Executive Committee referred to in this Policy as the Appeal Panel. The following rules apply to how Appeal Panels are formed:[3]

- The Chair of the Executive Committee is responsible for appointing Appeal Panels, and for naming the Appeal Panel chairperson.
- Appeal Panels will consist of at least three members of the Executive Committee or Council, one third of whom must be public representatives.
- If there are insufficient members of the Executive Committee or Council without a conflict of interest, then the Chair of the Executive Committee may appoint other public representatives or registrants of CPSM in accordance with the Council's Governance Policy.

5. How is an appeal started?

To initiate an appeal, the Complainant must give the Registrar a Notice of Appeal, including reasons for the appeal. The Notice of Appeal must be provided by the complainant within 30 days after receiving notice of the Investigation Committee's decision.[4]

The Notice of Appeal must be in writing and should clearly state what is being appealed and why (i.e., the reasons for requesting the appeal). The reasons for appealing, also referred to as the grounds for appeal, should include the specific procedural, factual, or legal errors that the Complainant believes were made by the Investigation Committee.

The Notice of Appeal should be brief and concise. Explanation and argument should be saved for the appeal submission document (see below). The Notice of Appeal should not include evidence, such as new facts or documents.

Examples of reasons or grounds for appeal may include:

- That inadequate investigation was conducted.
- Unreasonable analysis or inferences in respect to the facts and circumstances.
- Unreasonable conclusions about whether standards of care or professionalism were met based on the facts and circumstances.

[2] See section 91. C. of The Affairs of the College Bylaw.
[3] Subsections 108(3), 108(4) and 108(5) of the RHPA.
[4] Subsection 108(2) of the RHPA.

- Procedural unfairness or failure to follow proper procedure, including respecting the complainant's participatory rights.
- Unreasonable disposition given the findings.
- Biased decision maker.

The Complainant may choose to file their Notice of Appeal and submission as one document.

6. When does the appeal period start and end?

A Notice of Appeal cannot be accepted after the 30-day appeal period has expired.[5] With respect to the appeal period:[6]

- Notice on the Investigation Committee's decision is considered given when it is delivered personally, or when sent by registered mail or another service that provides CPSM with proof of delivery to the complainant's last recorded address.
    - Notice by registered mail is deemed to be given 5 days after the day it was sent.
    - Email notice is given when a delivery receipt is received.
- Complainants are reminded of the importance of maintaining up to date contact information with CPSM.

A Complainant who wishes to file a Notice of Appeal may contact CPSM for assistance or to request accommodations if they have difficulty completing a written Notice of Appeal. However, no extension of the timeline is possible.

7. Process upon receiving a Notice of Appeal.

Upon receiving a Notice of Appeal from a Complainant, the Registrar will acknowledge receipt and ask the Complainant if they intend to file a written submission (see below). If so, they have 30 days to provide the written submission. Notwithstanding, the Complainant will be asked to file submissions at their earliest convenience. In general, the Notice of Appeal and written submission are the only documents the Complainant should be providing in the appeal process.

The Registrar will provide a copy of the Notice of Appeal to the Investigated Registrant when it is received, copying their legal counsel if they have legal counsel. If a written submission is received from the Complainant, that will also be sent to the Investigated Registrant.

The Registrar will provide the Investigated Registrant with 30 days to make a written submission from the date they are provided with the Complainant's written submission or the date on which they are advised a written submission from the Complainant is not expected.

---

[5] Subsection 19(2) of *The Interpretation Act* states that "*Where, under any Act of the Legislature, the time limited for the registration or filing of any instrument, or for the doing of any thing, expires or falls on a day on which, pursuant to any statute or law in force in the province, the office or place in which the instrument or thing is required or authorized to be filed or done, is closed, the time so limited extends to, and the instrument or thing may be filed or done, on the first following day on which the office is open.*"

[6] Section 176 of the RHPA.

8. What is a written submission?

The submission should contain arguments, as well as references to the facts underlying the complaint and references to the Investigation Committee's process and decision that support the grounds of appeal. The purpose of the submission is to help the Appeal Panel:

- understand the Complainant's and Investigated Registrant's perspectives,
- apply the law, and
- reach a decision.

No written submission can be accepted after the 30-day period set by the Registrar has expired

9. Appeal Material.

The Registrar must include the following in the material submitted to the Appeal Panel:

- the Investigation Committee's decision,
- the Investigator's Report,
- the Notice of Appeal, and
- the written submissions of the Complainant and the Investigated Registrant.

Apart from the listed Appeal Material, the Appeal Panel will not accept any further information or records from the Complainant or the Investigated Registrant.

10. Date of meeting.

The Chair of the Executive Committee is responsible for fixing a date for the meeting of the Appeal Panel after all the Appeal Materials have been assembled.

11. Meeting.

When an Appeal Panel meets to consider an appeal:

- The Complainant and the Investigated Registrant are not permitted to attend.
- The Appeal Panel may have legal counsel to assist it in relation to the appeal.
- The Appeal Panel may request any additional information it deems necessary and may have access to the Investigator's Report or any documentation gathered by the Investigation Committee for the purposes of its investigation.
- The Appeal Panel may send clarifying questions to the Investigator prior to deciding the appeal.

12. New issues or evidence:

Appeals focus on the information used to make the original decision. In other words, appeals are 'on the record'.

When new evidence is presented, or new issues are raised, the Appeal Panel has the discretion to not consider the new evidence or issues, especially when it is clear they could have been raised

before the Investigation Committee. Absent significant countervailing public interest considerations, the Appeal Panel should be reluctant to consider new issues or evidence that was not before the Investigation Committee.

Where the complainant brings forward new evidence that the Appeal Panel is willing to consider, the Appeal Panel should assess whether that new evidence might reasonably impact upon the decision and, if so, whether the matter should be remitted to the Investigation Committee for reconsideration.

Appeals are generally restricted to matters that were determined by the Investigation Committee. Where the appeal raises a new issue, the Appeal Panel must assess its ability to fairly decide the matter based on the available information. If the Appeal Panel is unable to fairly decide the matter without additional information, the matter should be referred to the Investigation Committee to obtain the additional information.

13. Standards of review:

When reviewing an Investigation Committee decision, the Appeal Panel will apply the following standards of review to determine if the decision is based upon an error of fact, law or principle, or is otherwise not reasonably sustainable.[7]

- The Investigation Committee's **factual assessments**, including inferences drawn from its examination of the facts, are reviewed for reasonableness.[8] The Appeal Panel should afford a significant deference to the Investigation Committee's findings and examination of the facts, and only interfere based on an articulable reason for disagreeing with the Committee's assessment.

- Findings on questions of **mixed facts and law** (e.g., whether the standard of care was met based on the facts under review) require careful consideration of the nature of the error that is said to have occurred. A deferential standard is appropriate where the decision results more from consideration of the evidence, but a standard of correctness can be applied when the error arises from the statement of the legal test. The correctness standard promotes uniformity in interpretation of applicable standards of practice and ensures that proper professional standards are maintained.

- Legal compliance and **conclusions on issues of law** are reviewed for correctness. This may include questions of statutory interpretation, including interpretation of the RHPA, or true issues of jurisdiction. Again, this is to promote consistency and uniformity.

[7] The law relating to the applicable standard of review for internal appeals was considered in *Moffat v. Edmonton (City) Police Service*, 2021 ABCA 183.

[8] In summary, reasonableness is concerned with justification, transparency and intelligibility. A decision is unreasonable if it is internally incoherent or if it is untenable having regard to the relevant factual and legal constraints.

- Questions about the application of common law rules of natural justice and **procedural fairness** are reviewed to see whether the appropriate level of due process or fairness required by the statue or common law has been afforded.

- **Discretionary decisions**, including how the Investigation Committee decided to resolve the complaint, are reviewed against the standard of reasonableness. The disposition should fall within a range of possible, acceptable conclusions which are defensible in respect of the facts, circumstances, and law.

- The test on review for **bias** is whether a reasonable person, viewing the matter realistically and practically, and after having obtained the necessary information and thinking things through, would have a reasonable apprehension of bias.

- In terms of the **adequacy of the investigation**, the Appeal Panel will typically defer to the Investigation Committee's expertise and discretion, unless there is evidence that the investigation was conducted in a manner that is clearly deficient or unreasonable. For example, when the Appeal Panel finds the Investigation Committee failed to follow proper procedures, failed to gather key or essential evidence necessary to inform a reasonable disposition, or ignored critical aspects of the complaint, then it may intervene. The Appeal Panel may intervene where there is either no investigation or only a cursory investigation that is inconsistent with the nature of the complaint or goals of the investigation.

Overall, the Appeal Panel is well-position to review the entire decision and conclusion of the Investigation Committee for reasonableness, to ensure that it properly protects the public and reputation of the profession.

As an overriding principle, the Appeal Panel should not interfere simply because it might have reached a different conclusion on the case.

14. Powers of the Appeal Panel.

Appeal Panels can exercise the following powers:

- dismiss the appeal,
- make any decision that in its opinion ought to have been made by the investigation committee, or
- refer the matter back to the investigation committee for further investigation or consideration in accordance with any direction that the panel may give.

15. Reasons.

Reasons for the decision will be drafted by the chair of the Appeal Panel, usually with the input of legal counsel. Reasons should:

- address the major points in issue,
- explain why the Appeal Panel reached the decision which it made (i.e., show the reasoning which formed the basis of the decision), and

- show that the Appeal Panel did consider the points raised.

Although reasons need not be elaborate, they must be sufficient to permit the complainant and the physician to be able to say that they know what the result is and the basis upon which the decision was reached.

16. Referral to the Investigation Committee.

In cases where the Appeal Panel refers a matter back to the Investigation Committee for further investigation, the second decision of the Investigation Committee is to be treated as a new decision and is subject to a right of appeal by the complainant.

17. Notice of decision.

The Appeal Panel's decision and the reasons for it must be communicated to the Complainant, the Investigated Registrant and the Assistant Registrar, Complaints and Investigations, in writing by way of a written Notice of Decision and Reasons for Decision.

18. No further right of appeal.

There is no appeal from the Appeal Panel's decision.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL POLICY

Appeal Guidelines of Investigation Committee Decisions

Initial Approval: June 15, 2004

Effective Date: January 1, 2019

Reviewed with NO Changes
November 22, 2018

Reviewed with Changes
March 14, 2008
September 13, 2013
September 29, 2017 – To take effect June 15, 2018

The Appeal Panel of the Executive Committee ("Appeal Panel") adheres to the principle of law that for the exercise of a discretionary power, that discretion must be brought to bear on every case, and each case must be considered on its own merits. Within that context, the following general guidelines apply to appeals:

1. Appeals from decisions of Investigation Committee are not fresh hearings of the matter. Accordingly, the question for the Appeal Panel is not the question which was before the Investigation Committee. The functioning of the Appeal Panel is to examine the Investigation Committee decision to determine whether there was an error of fact, of law, or of procedure.

2. Appeals are generally restricted to matters actually determined by the Investigation Committee. Where the appeal raises a new point, the Appeal Panel must assess its ability to fairly decide the matter on the basis of the available information. If the Appeal Panel is unable to fairly decide the matter without additional information, the matter should be referred back to the Investigation Committee to obtain the additional information.

3. Where the appellant brings forward new evidence, the Appeal Panel should assess whether that new evidence might reasonably impact upon the decision and, if so, whether the matter should be remitted to the Investigation Committee for reconsideration in light of the new evidence.

4. In the absence of an allegation of bias on the part of the Investigation Committee, the Appeal Panel's threshold test for intervention is that the Investigation Committee's decision contains an error of fact, of law or of procedure which warrants interference. The Appeal Panel should not interfere simply because it might have reached a different conclusion on the case.

5. Reasons for decision will be drafted by the Chair of the Panel with the input of legal counsel.

6. Reasons should:
    6.1. address the major points in issue.
    6.2. explain why the Appeal Panel reached the decision which it did, i.e. show the reasoning which formed the basis of the decision.
    6.3. show that the Appeal Panel did consider the points raised.

    Although reasons need not be elaborate, they must be sufficient to permit the complainant and the physician to be able to say that they know what the result is and the basis upon which the decision was reached.

In cases where the Appeal Panel refers a matter back to the Investigation Committee for further investigation, the second decision of the Investigation Committee is to be treated as a new decision and is subject to a right of appeal by the complainant.

PRACTICE DIRECTION
Appeals from Investigation Committee Decisions

Initial Approval: March 23, 2022 **Effective Date: March 23, 2022**

Revision Date: December 14, 2022

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

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

1. Appeals from Investigation Committee Decisions

1.1. Where a matter may be heard by an appeal panel of Council pursuant to s. 108 of the RHPA, the appeal will ordinarily be heard by a Panel of the Executive Committee in accordance with the authority delegated to it by Council pursuant to Part F of the Affairs of the College and Code of Ethics Bylaw and in any event in accordance with the following criteria:

1.1.1. This panel must consist of at least three members of Council who will sit on the panel, one third of whom must be public representatives.

1.1.2. If there are insufficient members of Council without a conflict of interest, the Chair of Council may appoint registrants of CPSM who are not members of Council, provided at least one third of this panel is composed of public representatives.

1.1.3. No person may be appointed to this panel who has taken part in the review or investigation of the matter that is the subject of the appeal.

1.2. The process for the hearing and determination of the appeals from a decision of the Investigation Committee set out in this Practice Direction supplements the mandatory requirements of sections 108 through 109 of the RHPA as amended by Part 14 of the RHPA.

1.3. Section 108(1) of the RHPA limits the right of appeal of a complainant in respect to any decision made by the Investigation Committee to only those decisions in which the Investigation Committee does one or more of the following:

1.3.1. directs that no further action be taken;
1.3.2. accepts an undertaking from the investigated registrant; or
1.3.3. takes any other action it considers appropriate that is not inconsistent with or contrary to this Act or the regulations or by-laws.

1.4. To initiate an appeal, the complainant must give the Registrar a written notice of appeal, including reasons for the appeal, within 30 calendar days after receiving notice of the Investigation Committee's decision. No appeals can be accepted after the appeal period has expired.

1.5. The complainant may make a written submission within 30 calendar days after providing written notice of appeal and reasons. No written submission can be accepted after the appeal period has expired

2. Procedure on Receipt of Notice of an Appeal

2.1. Upon receipt of Notice of Appeal pursuant to section 108(1) of the RHPA, the Registrar must acknowledge receipt of the Notice of Appeal to the complainant and provide a copy of the Notice of Appeal to the investigated registrant.

2.2. Both the complainant and the investigated registrant will have 30 calendar days within which to make a written submission.

3. Date of Hearing the Appeal

3.1. The Chair of Council is responsible to fix a date for the hearing of the appeal after all the Appeal Material has been assembled.

4. Appeal Material

4.1. The Registrar must include the following in the material submitted to Appeal Panel for its consideration of an appeal of an investigation committee decision:
4.1.1. The Investigation committee decision;
4.1.2. The Notice of Appeal; and
4.1.3. The written submissions of the Complainant and the Investigated registrant.

5. Meeting

5.1. When an Appeal Panel meets to consider an appeal:
5.1.1. Neither the complainant nor the investigated registrant is permitted to attend the meeting.

5.1.2. The Panel may have legal counsel to assist it in relation to the appeal.
5.1.3. The Panel may request any additional information it deems necessary and have access to the Investigator's Report and any documentation gathered by the investigation committee for the purposes of its investigation.

6. Appeal Panel Decision

6.1. Appeal Panels have the ability to exercise the following powers:
6.1.1. dismiss the appeal;
6.1.2. make any decision that in its opinion ought to have been made by the investigation committee; or
6.1.3. refer the matter back to the investigation committee for further investigation or consideration in accordance with any direction that the panel may give.

6.2. Appeals from decisions of Investigation Committee are not fresh hearings of the matter. Appeal Panels adhere to the principle of law that for the exercise of a discretionary power, that discretion must be brought to bear on every case, and each case must be considered on its own merits. Within that context, the general guidelines established by Council Policy apply to appeals from decisions of the Investigation Committee.

6.3. Both the investigated registrant and the complainant must be given written notice of the Appeal Panel's decision and the reasons for it.

6.4. The Appeal Panel's decision and the reasons for it must be communicated to the complainant, the investigated registrant and the Medical Consultant to the Investigation Committee in writing by way of a written Notice of Decision and Reasons for Decision.

6.5. There is no appeal from a decision of the Appeal Panel.

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Amendment to the Council Policy – Specialist Register

BACKGROUND:

The Council Policy for the Specialist Register (*Appendix A*) was recently updated to expand t hose eligible for registration on the Specialist Register. Certain categories of full registration were inadvertently missed. Adding a new "*special circumstance*" at section **2.2** is therefore recommended as follows:

> *The applicant has achieved full registration by virtue of a domestic trade agreement in accordance with subsection **32(3)** of the RHPA or under the provisions of The Medical Act (now repealed) and they are licensed to practice in the applicable specialty field.*

The footnote for this addition will indicate:

> *For example, this applies to registrants who achieve full registration under The Medical Act through practice experience, or specialists who are registered under the provisions of the CFTA*.

This change would benefit labour mobility applicants who become fully registered and who do not have Royal College certification (e.g., those fully registered with other MRAs based on American Boards).

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

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

COUNCIL POLICY

Specialist Register

Initial Approval: December 13, 2023 **Effective Date: December 13, 2023**

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

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

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

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

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

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

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

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

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

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

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

2.2.5. The applicant has achieved full registration by virtue of a domestic trade agreement in accordance with subsection 32(3) of the RHPA or under the provisions of *The Medical Act* (now repealed) and they are licensed to practice in the applicable specialty field.[4]

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

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

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

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

[4] For example, this applies to registrants who achieve full registration under *The Medical Act* through practice experience, or specialists who are registered under the provisions of the CFTA.

COUNCIL MEETING
DECEMBER 18, 2024

NOTICE FOR MOTION OF APPROVAL

SUBJECT: **Recommended Changes to Practice Direction - Professional Practice and Inactivity.**

BACKGROUND:

Section **7.3** of the Practice Direction – Professional Practice and Inactivity (the "Practice Direction" see *Appendix A*) can confusedly be interpreted to preclude family physicians from providing prenatal care to women beyond 14 weeks of pregnancy. It is not the intention of the Practice Direction to limit prenatal care in this manner.

A registrant who practices and teaches in the area of maternal care and women's health contacted CPSM to provide feedback on the Practice Direction. Staff met with the physician to discuss. Their concerns related primarily to section **7.3**, which reads:

> *Family practice including obstetrics*
> ***7.2.*** *Physicians registered to practice in the field of family medicine must not practice obstetrics unless the following conditions are met:*
>
> > ***7.2.1.*** *The family practice physician must have completed acceptable post-graduate clinical training in obstetrics and practiced obstetrics within the past three (3) years.*
> >
> > > ***7.2.1.a.*** *Family practice physicians who do not meet the foregoing requirement and wish to provide obstetrical care must do so in accordance with the Council Policy - Assessment Candidate (Re-entry to Practice) Class. This must include completing acceptable postgraduate clinical training in obstetrics, if not already completed.*
> >
> > ***7.2.2.*** *Family practice physicians who are registered with entitlement to practice obstetrics, but who have not performed any deliveries for more than three (3) years may provide prenatal care to patients but may not do deliveries.*
>
> ***7.3.*** *Family practice physicians who have not completed acceptable postgraduate clinical training in obstetrics and who are not registered with entitlement to practise obstetrics must refer a patient to an appropriately qualified physician:*
>
> > ***7.3.1.*** *Before fourteen (14) weeks of pregnancy, or*
> > ***7.3.2.*** *if the diagnosis is established after fourteen (14) weeks, as soon as possible after diagnosis.*

Specific concerns raised included:

- The reference to "*acceptable postgraduate clinical training in obstetrics*" is vague. Physicians may not be clear about whether they have this training.
- The reference to making a referral before 14 weeks of pregnancy, or as soon as possible after diagnosis (if diagnosis is made after 14 weeks) may cause physicians to assume that they cannot provide obstetrical care to pregnant patients after 14 weeks of pregnancy and must refer patients to an appropriately qualified physician.
- The physician advised that family medicine practitioners may read sections **7.3.1** and **7.3.2** and conclude that they do not have acceptable obstetrics training and cannot provide obstetrical care to patients who are more than 14 weeks pregnant.
- They explained that some family medicine practitioners have obstetrics training noted in their practitioner information. Members of the public and registrants may become confused when they see family medicine physicians who are not listed as having obstetrical training since these physicians can still provide obstetrical care.

CPSM consulted another family physician from academia, who commented as follows:

> ***1.*** *In general, physicians are deemed competent to determine their limitations, and only provide care that are within their scope and training. When we have reached our limit, either in area where we have limited experience, or area where experience was distant, we are trusted to consult colleagues with greater expertise. Therefore, having many restrictions in practice directions can have significant impact on health care deliveries, esp. in traditionally underserved areas, where having any provider is difficult, let alone those with additional qualifications.*
>
> ***2.*** *I agree that complicated pregnancies, and deliveries may need some practice directions.*
>
> ***3.*** *In regards to providing (prenatal) obstetrics care, especially in routine, low risk settings, it is completely within the scope of family physicians without additional training (all of them have obstetrics post grad training incorporated in residency)[1] to do most test ordering/monitoring up to 28 weeks, if not later. After 28 weeks, it may be beneficial to have obstetrics involved as they may want to know the patients better in anticipation to delivery.*
>
> ***4.*** *Especially for rural communities, if routine low risk prenatal care cannot be delivered (esp. if it is against practice directions which all members are expected to comply), there will be significant impacts on delivering prenatal care to patients where there is no provider with "acceptable post grad clinical training) in their community.*

[1] **The refers to Canadian FM residencies and substantial similar programs in other jurisdictions.**

> ***5.*** *Yes, I support* ***7.3*** *being removed from the article, as acceptable post grad is not clearly defined, and 14 weeks is very restrictive compared to common comprehensive practice.*

Analysis

Historically, CPSM would consider anyone who has completed a typical Canadian FM Residency program or the MLPIMG program to have 'acceptable postgrad clinical training in obstetrics. The important component is rotations in obstetrics.

The relevant question concerns whether there a need for a practice direction to specifically focus on a narrow area or aspect of family medicine practice. Other specialties do not have practice direction provisions such as section **7.3.** One criticism is that having too many nuanced directives could hypothetically create a floodgate of future practice direction amendments.

The primary intention of sections **7.2** and **7.3** in the current Practice Direction is to ensure that Family Physicians providing intrapartum care have current and relevant expertise in this specific skillset. However, that is already generally covered by the overall Practice Direction.

Removing section **7.3** would remove any confusion regarding the provision of prenatal care by Family Physicians, and any implications that Family Doctors can only provide prenatal care up to a specific gestation. This would be in contrast with CMPA coverage, which we understand would cover a non-obstetrical Family Physician to all care short of a labouring patient and is not guided by gestational age, but the type of care provided, intrapartum care excluded.

The stipulation would remain with section **7.2** that anyone providing intrapartum care (and by extension holding privileges to admit to hospital to provide this care) would have been active in this type of care within a three-year period, otherwise would require retraining to resume intrapartum care, which is reasonable from our perspective.

Pursuant to section **83(d)** of The Affairs of the College Bylaw proposed amendments to a Practice Direction must be posted on the CPSM website for consultation.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the Practice Direction – Professional Practice and Inactivity with proposed amendments be sent out to registrants, stakeholders, and the public for consultation.

PRACTICE DIRECTION

Professional Practice and Inactivity

Initial Approval: June 28, 2023 **Effective Date: June 28, 2023**

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

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

PREAMBLE

This Practice Direction sets out requirements for registrants regarding the need to recognize the limits of their skills and knowledge, and steps that need to be taken when expanding their professional practice to enter areas of inactivity (e.g., new areas of practice). It also includes special requirements for family physicians to include obstetrics or anaesthesia in their professional practice.

CONTENTS

1. APPLICATION OF THIS PRACTICE DIRECTION

1.1. This Practice Direction applies to all regulated registrants (i.e., full, and provisionally registered physicians) and all regulated associate registrants who are registered as a resident or assessment candidate. The professional practice of Clinical and Physician Assistants is determined by their approved Practice Descriptions (see Part 8 of the *CPSM General Regulation*), which are not the subject of this Practice Direction.

2. DEFINITIONS

2.1. For the purposes of this Practice Direction:

'Area of inactivity' means an area of practice in which a registrant has not practiced within three (3) or more years. This includes an area in which the registrant has never practiced.

'Professional practice' has the same meaning as is set out at subsection 1.2(1) of the *CPSM General Regulation*:

> '*professional practice' means, for the purpose of the CPSM General Regulation, a member's specific area of practice in a field of practice within the scope of the practice of medicine."*[1]

The term **'active scope of practice'** as used in this Practice Direction is interchangeable with the term **'professional practice'**. A registrant's active scope of practice (or professional practice) includes their:

- **'practiced scope'**, which means the usual activities that constitute a registrant's core professional practice, and
- **'available scope'**, which means activities that the registrant can safely and competently perform, such as diagnosis and treatment of rarely encountered conditions, and therefore forms part of the registrant's active scope of practice.

3. REGISTRANT'S PROFESSIONAL PRACTICE

<u>Active scope of practice</u>

3.1. A registrant's active scope of practice (or professional practice) is determined by several factors including formal education, training, and certification(s), participation

[1] Section 3 of the *Practice of Medicine Regulation* further defines the "*scope of practice of medicine*" for the purposes of the RHPA.

in continuing professional development, and the registrant's clinical experience. Relevant factors to consider regarding clinical experience include:

- the patient population and demographics,
- reserved acts and procedures performed,
- differential diagnoses or complications addressed in practice,
- treatments and management provided, including prescribing, and
- the practice environment, including practice context (e.g., institutional, or non-institutional, and available supports and resources).[2]

3.2. Information about a registrant's professional practice is obtained by CPSM at the time of initial registration.[3] Applicants for registration are required, as applicable depending on the class applied for, to establish that they have engaged in the professional practice that they intend to practice in Manitoba within the approved period, which is three (3) years (i.e., the recency of practice requirement). In the case of an applicant who has just completed qualifying post-graduate medical education, the recency requirement is satisfied.

3.2.1. Applicants for registration that do not meet the recency of practice requirement may be eligible for registration as an assessment candidate.[4]

3.3. Regulated registrants (i.e., full, and provisional registrants) initially entering the independent practice of medicine do so based on their registrable qualifications and credentials, which comprehend their medical education, training, and clinical experience. They are limited in scope by their learned competencies and the certificate of practice issued by CPSM, which lists their field of practice and may also list exclusions, inclusions, or other terms and conditions.

<u>Field of practice</u>

3.4. Pursuant to the *CPSM General Regulation*, Manitoba has a defined licencing system for medical practitioners. Accordingly, the professional practice of registrants is limited to the field of practice identified in their certificate of practice subject to any denoted inclusions, exclusions, or other terms and conditions.

3.4.1. The interpretation or understanding of what the named field of practice comprises, including the reserved acts that fall within that field of practice (see section 4 of the RHPA), is a matter of professional convention. CPSM will

[2] Subsection 9.6(1)(i) of the *CPSM General Regulation* provides that a registrant's public profile information must include "*in the case of a regulated member, [their] current field or fields of practice and, if the registrar considers it necessary or advisable, the member's current professional practice*".

[3] Subsection 3.2(1) of the *CPSM General Regulation* at point 11 requires that applicants for membership provide, "*A satisfactory description of the applicant's most recent professional practice and proposed professional practice*."

[4] See the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class'.

generally follow descriptions of fields of practice established by the CFPC and the RCPSC. The registrant's specific post-graduate medical education will also be a relevant factor (i.e., residency, fellowship, and professional credentials).

3.4.2. There is no bright-line test to delineate fields of practice, and specific medical procedures or reserved acts are not always compartmentalized to just one field (e.g., family practice, or specialty field of practice). In this regard, registrants' specific education, training, experience, and professional judgment respecting observance of their limitations is important in resolving grey areas.

3.4.3. Listing the field of practice on a registrant's Public Profile (see Part 9 of the *CPSM General Regulation*) and any inclusions, and exclusions, or other terms and conditions, is integral to CPSM's public protection mandate in that it ensures the public has access to a specific registrant's educational background and authorized professional practice.

3.5. Areas of special interest may also be listed on the Public Profile. Section 6.7. of the *CPSM General Regulation* provides for the use of the phrase "*special interest in*" or "*practice restricted to*":

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

<u>Name under which registrants may engage in practice</u>

3.6. No registrant or medical corporation may practice medicine under any name other than the name that is registered with CPSM, unless the Registrar has approved, in writing, the name under which the registrant or medical corporation intends to practice medicine. A registrant or medical corporation desiring to practice under the

name of a clinic, facility or business name that is not registered with CPSM, must send a written request to the Registrar to approve the name the registrant or medical corporation wishes to practice under. The name under which a registrant or medical corporation practices medicine must be published on their Physician Profile.

4. PRACTICE MUST BE SAFE AND COMPETENT

4.1. As a general and overarching requirement, registrants must be safe and competent to practice in a particular area of practice before they may do so. Section 1.3. of the *CPSM General Regulation* provides:

> *1.3 For the purpose of [the CPSM General Regulation], a member is considered to be competent to engage in [their] professional practice if the member has the requisite knowledge, skill and judgment to perform all aspects of that practice.*

4.2. Registrants are expected to recognize the limits of their skills and knowledge and not practice beyond those limits. The Code of Ethics provides:

> *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.*

4.3. The RHPA and *Practice of Medicine Regulation* set out requirements related to the performance of reserved acts:[5]

4.3.1. Subsection 6(1) of the *Practice of Medicine Regulation* states that, "*In the course of engaging in the practice of medicine, a member is authorized — subject to the regulations made by the council and any conditions on [their] certificate of registration or certificate of practice — to perform the reserved acts referred to in section 4 of [the RHPA]*."

4.3.2. Subsection 6(2) states that "*Despite subsection (1), a member may only perform a reserved act that he or she is competent to perform and that is safe and appropriate to the clinical circumstance*".

4.4. Registrants are expected to remain current in their professional practice. The Code of Ethics provides that registrants are expected to:

- *Develop and advance your professional knowledge, skills, and competencies through lifelong learning.*

[5] See sections 4 and 5 of the RHPA.

- *Foster curiosity and exploration to further your personal and professional development and insight; be open to new knowledge, technologies, ways of practising, and learning from others.*

4.5. All registrants of CPSM are required to meet the continuing competency requirements set out at Part 10 of the *CPSM General Regulation* and CPSM's Continuing Professional Development Practice Direction.

5. EVOLUTION OF PROFESSIONAL PRACTICE VERSUS ENTERING AN AREA OF INACTIVITY

5.1. A registrant's professional practice can change over time, with some aspects being lost to inactivity or gained through appropriate training, education, and experience.

5.2. For the purposes of the *CPSM General Regulation* and this Practice Direction, a registrant or applicant for registration who has not practiced within an area or areas of practice within three (3) years, which is the considered "*the approved time period*" for the purposes of subsections 3.8(c), 3.44(1)(ii), and 3.44(2)(ii) of the *CPSM General Regulation*, is deemed to be inactive in the respective area or areas (i.e., the area is outside their active scope of practice).

5.2.1. For greater clarity, a registrant or applicant who has not practiced medicine at all for a continuous period of three (3) or more years is considered inactive in all areas of the scope of practice of medicine for the purposes of the *CPSM General Regulation*.

5.3. Registrants are not permitted to practice in a new area (i.e., an area of practice where they are inactive) unless and until they have been approved to do so in accordance with sections 3.44 to 3.47 of the *CPSM General Regulation* (i.e., the assessment provisions).[6]

5.3.1. As an exception, this assessment requirement does not apply to registrants entering professional practice in a position focused on clinical teaching, research, or administrative work.

5.3.2. For the purposes of the *CPSM General Regulation* and this Practice Direction, CPSM does not consider adding non-surgical cosmetic/aesthetic procedures to a member's professional practice as entering a new area of practice. However, this must be done in accordance with CPSM's Standard of Practice for Office Based Procedures.[7]

5.4. Relevant considerations in determining whether a registrant is entering an area of inactivity (i.e., significantly changing their professional practice to include one or more new areas of practice), as opposed to an evolution of an ongoing professional

[6] See the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class'.

[7] See Standard of Practice for Office Based Procedures.

practice that does not require assessment (e.g., adopting a new treatment modality), include the following:

5.4.1. whether the subject matter falls within an area of practice that was covered by past formal education, training, or certification,

5.4.2. whether the subject matter has been a focus of continuing professional development,

5.4.3. whether the registrant has the knowledge, skill, and judgment to perform all aspects of the area of practice,

5.4.4. any significant change in patient population or demographics,

5.4.5. whether the subject matter involves the performance of reserved acts not previously included in the member's area of practice,

5.4.6. whether the subject matter involves differential diagnoses or complications not previously included in the registrant's area of practice,

5.4.7. whether the subject matter involves treatments or management not previously included in the registrant's area of practice, and

5.4.8. any significant changes to the practice environment, including practice context (e.g., institutional, or non-institutional, available supports and resources, etc.).

5.5. Inactivity may result from a general absence from all clinical activity or specific absence from one or more areas (i.e., the registrant or applicant has excluded one or more areas of clinical practice either through restriction of their practice or by virtue of their practice in a specific practice setting). Examples of inactivity include registrants or applicants for registration who have not practiced in relation to one or more of the following areas in the previous three-year period:

- chronic pain management,
- addictions medicine,
- endoscopy,
- public health,
- rural or urban emergency medicine,
- skin disorders,
- sleep medicine, and
- surgical cosmetic/aesthetic medicine.

This is not an exhaustive list.

5.6. Registrants are expected in all circumstances to use good clinical judgment in considering whether they are significantly changing their professional practice to include one or more areas of inactivity.

5.6.1. Registrants who are uncertain should contact the Registrar of CPSM for information.

5.7. Registrants or applicants who wish to practice in an area or areas of inactivity are required to comply with Part 6 of this Practice Direction.

6. ENTERING OR RE-ENTERING AN AREA OF INACTIVITY

Practicing registrants changing professional practice to enter an area of inactivity:

6.1. Regulated registrants registered in the Full (Practising) Class, Provisional (Specialty Practice-Limited) Class, or the Provisional (Family Practice-Limited) Class who intend to change their professional practice to include one or more new areas of practice in which they have not practiced within the previous three (3) years (i.e., areas of inactivity) must:

6.1.1. report their intention to CPSM in accordance with the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class',

6.1.2. apply in the approved form to be assessed in accordance with subsection 3.44(1) of the *CPSM General Regulation*, and

6.1.3. refrain from entering the area of inactivity until they are approved to do so by the Registrar.

New applicants and non-practicing registrants re-entering practice:

6.2. Applicants who are:

6.2.1. registrants in a non-practising class and are inactive, or

6.2.2. applicants for registration with CPSM who are not registered in any class and who meet the requirements for the Full (Practising) Class, Provisional (Academic — S. 181 Faculty) Class, Provisional (Specialty Practice-Limited) Class, or Provisional (Family Practice-Limited) Class but for recency of practice requirement (i.e., have not practiced in three (3) years)

must apply to be assessed in accordance with subsection 3.44(2) of the *CPSM General Regulation* before they may be approved to re-enter the practice of medicine. The 'Council Policy - Assessment Candidate (Re-entry to Practice) Class' sets out applicable policies and procedures.

New applicants with recent practice experience entering an area of inactivity:

6.3. CPSM requires that new applicants for membership provide details about their most recent professional practice and their intended professional practice in Manitoba. Applicants are required to advise whether their intended practice includes areas of inactivity. Applicants who meet the requirements for full or provisional registration who wish to enter an area of inactivity will be registered in the usual way but must apply in the approved form to be assessed in accordance with subsection 3.44(1) of the *CPSM General Regulation*, and refrain from entering the area of inactivity until they are approved to do so by the Registrar. The 'Council Policy - Assessment Candidate (Re-entry to Practice) Class' sets out applicable policies and procedures.

Required assessment respecting section 3.44 of the *CPSM General Regulation*:

6.4. The degree of assessment indicated and extent of any additional education and training that may be required before approval is granted to enter an area or areas of inactivity will depend on the nature of the re-entry or change in professional practice. The individualized process for determining these components in respect to assessment candidates will be determined by the Registrar under section 3.44 of the *CPSM General Regulation*, this Practice Direction, and the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class', which sets out applicable policies and procedures. The process will usually include:
6.4.1. a needs assessment,
6.4.2. any necessary training and education,
6.4.3. review of appropriate terms and conditions, and
6.4.4. a final assessment where appropriate.

7. FAMILY PRACTICE INCLUDING OBSTETRICS OR ANAESTHESIA

Family practice with anaesthesia

7.1. Pursuant to subsections 2.5(1)(c) and 2.10(2) of the *CPSM General Regulation*, registrants who practice family medicine will have one of the following indicated in the registry: family practice with anaesthesia or family medicine without anaesthesia. The Registrar may only grant registration and a certificate of practice to family practice physicians with anaesthesia included if the physician has satisfactorily completed twelve months of formal training in anaesthesia in an approved teaching centre.
7.1.1. Family practice physicians holding registration and a certificate of practice expressly including anaesthesia as of the implementation of this Practice Direction may continue to hold that registration and a certificate of practice even though they may not meet the foregoing requirement.
7.1.2. The Registrar must impose the following conditions on the registration and certificate of practice of family practice physicians including anaesthesia in their practice:
7.1.2.a. Except in emergencies, limit anaesthesia to patients in physical status I, II and III according to the American Society of Anaesthesiologists Protocol:
7.1.2.a.i. ASA I - A normal healthy patient.
7.1.2.a.ii. ASA II - A patient with mild systemic disease.
7.1.2.a.iii. ASA III - A patient with severe systemic disease that limits activity but is not incapacitating.
7.1.2.a.iv. ASA IV - A patient with an incapacitating systemic disease that is a constant threat to life.

7.1.2.a.v. ASA V - A moribund patient not expected to survive 24 hours with or without operation.

7.1.2.b. Anaesthesia for intrathoracic or neurosurgical procedures must not be undertaken.

7.1.2.c. Anesthesia for any child before they are three (3) years old must not be undertaken.

Family practice including obstetrics

7.2. Physicians registered to practice in the field of family medicine must not practice obstetrics unless the following conditions are met:

7.2.1. The family practice physician must have completed acceptable post-graduate clinical training in obstetrics and practiced obstetrics within the past three (3) years.

7.2.1.a. Family practice physicians who do not meet the foregoing requirement and wish to provide obstetrical care must do so in accordance with the Council Policy - Assessment Candidate (Re-entry to Practice) Class. This must include completing acceptable post-graduate clinical training in obstetrics, if not already completed.

7.2.2. Family practice physicians who are registered with entitlement to practice obstetrics, but who have not performed any deliveries for more than three (3) years may provide prenatal care to patients but may not do deliveries.

7.3. Family practice physicians who have not completed acceptable postgraduate clinical training in obstetrics and who are not registered with entitlement to practise obstetrics must refer a patient to an appropriately qualified physician:

7.3.1. Before fourteen (14) weeks of pregnancy, or

7.3.2. if the diagnosis is established after fourteen (14) weeks, as soon as possible after diagnosis.

COUNCIL MEETING
DECEMBER 18, 2024
BRIEFING NOTE

SUBJECT: President-Elect Nomination

BACKGROUND:

Pursuant to section 39a of *The Affairs of the College Bylaw* the Executive Committee nominates Dr. Kevin Convery for the office of President-Elect effective June 25, 2025.

Dr. Convery has represented the East Electoral District since June 2018 and has been Chair of the Investigation Committee since June 2020.

At the December 18, 2024 meeting the Chair must, pursuant to section 39c of *The Affairs of the College Bylaw*, ask for nominations from the floor for the office of President-Elect. Only Councillors present (either in person of virtually) are eligible to nominate from the floor, and a Councillor may nominate themselves as a candidate for President-Elect.

If no eligible regulated registrant Councillors are nominated from the floor Dr. Convery will be acclaimed to the office of President-Elect effective June 25, 2025.

If another eligible regulated registrant Councillor accepts a nomination from the floor, the Registrar will conduct an election in accordance with the process specified in section 39d of *The Affairs of the College Bylaw*.

Eligible regulated registrant Councillors are:

- Dr. Kevin Convery
- Dr. Caroline Corbett
- Dr. Chaitasi Intwala
- Dr. Rizwan Manji
- Dr. Jennifer McNaught
- Dr. Lisa Monkman
- Dr. Peter Nickerson
- Dr. Alewyn Vorster

The Affairs of the College Bylaw appointment of the President-Elect provisions are:

> **39.** The President-Elect must be appointed from Councillors who are regulated registrants, according to the following process:

a. Commencing in 2018, in every second year, the Executive Committee must present a report to Council prior to December, recommending at least one nominee for the office of President-Elect.

b. In each year when appointment to the office of President-Elect is required, the Executive Committee's report must be included in the agenda material distributed to Councillors in advance of the December Council meeting.

c. At the December Council meeting, the Chair must ask for nominations from the floor for the office of President-Elect, provided that only Councillors present (either in person or through electronic means) are eligible to nominate from the floor, and that a Councillor may nominate himself or herself as a candidate for President-Elect.

d. If more than one candidate is nominated for President-Elect, the Registrar must conduct an election by Councillors according to the following process:

i. No later than the first Wednesday following the December Council meeting, provide to each Councillor:

1. A form of ballot that lists the names in alphabetical order of all candidates nominated;

2. Voting instructions, including the date and time by which votes must be received by the Registrar; and

3. Such other material as may be required.

ii. Upon receipt of a vote, the Registrar must be satisfied that it is the vote of a Councillor entitled to vote.

iii. The candidate for whom the highest number of votes is cast will be appointed as President-Elect.

iv. In the event of a tie vote, the President shall cast the deciding vote.

v. Any of the candidates for President-Elect may be present at the counting of the ballots.

vi. The Registrar must resolve any dispute or irregularity with respect to any nomination, ballot or election.

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

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

BACKGROUND:

To operationalize some of the 7 TRC Advisory Circle recommendations that were adopted by Council, a TRC Working Group was formed to create a Standard of Practice – Practicing Medicine to Prevent Indigenous Specific Racism.

The Working Group members: Dr. Lisa Monkman (Chair), Dr. Wayne Clark, Eileen Gelowitz, Dr. Sarah Goulet, Dr. Nicole Vosters, and Tessa Blaikie Whitecloud. CPSM staff support: Dr. Anna Ziomek, Registrar (now retired), Dr. Sonja Bruin, Assistant Registrar (Quality Department), Mike Triggs, General Counsel, and Karen Sorenson, Executive Assistant.

The Working Group retained Crystal Laborero for expert advice on consultation and drafting.

The Working Group began this project in August 2023. The steps taken to develop the Standard of Practice now entitled *Practicing Medicine to Eliminate Anti-Indigenous Racism* were to:

1. Inform the Assembly of Manitoba Chiefs, Manitoba Keewatinowi Okimakanak, Manitoba Inuit Association, Manitoba Métis Federation, Southern Chiefs' Organization, and Winnipeg Indigenous Executive Circle of the project and seek their participation.
2. Meet with Indigenous community leaders who have purview on the area of health care.
3. Meet with Indigenous health care providers.
4. Meet with Manitoba Métis Federation.
5. Prepare draft Standard of Practice and Contextual Information Documents.
6. Circulate draft documents with prior participants, additional Indigenous health care providers and experts in anti-racism.
7. Meet with Doctors Manitoba and CMPA.
8. Redrafted documents.
9. Seek additional feedback from prior participants.
10. Submit draft the Standard of Practice along with the Contextual Information Document for the 30-day consultation process.
11. Review consultation submissions.
12. Make revisions based upon consultation feedback.

The consistent themes that emerged were:

- anti-Indigenous racism is causing harm to Indigenous Peoples,

- to address anti-Indigenous racism registrants and the systems in which they practice medicine need to have an awareness of what anti-Indigenous racism looks like and how it manifests,
- registrants must be accountable for how they practice medicine,
- accountability includes learning how to be a better health care provider to Indigenous patients,
- proper application of the Code of Ethics will eliminate anti-Indigenous racism from the practice of medicine.

The consultation feedback, which is attached as *Appendix A* provided praise and criticism. The Working Group appreciated the praise and valued the criticism as a tool to improve the document.

It is noted that criticism of the consultation draft was significantly directed to the "reporting requirements" and the expectation that registrants will be punished for failing to comply with the standard or report colleagues.

An irony is noted.

The fear of CPSM and the potential use of the Standard as an instrument of punishment is based on the history and reputation of CPSM as a colonial organization that used fear of punishment as a means of ensuring compliance.

The intention of the Working Group and CPSM is to adopt a different approach. Enforcement of the Standard is through learning and a desire for self-improvement to be a better physician. Enforcement is accomplished through a restorative approach where healing and improvement are the goal. As the CMPA noted, discipline should be reserved for only egregious acts.

The Working Group's recommended edits (see *Appendix B*) to the consultation draft to address the following:

1. Clarify the intention that enforcement of the *Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism* is through a restorative approach as opposed to traditional complaints process.
2. Improve clarity of various provisions through:
    a. Grammatical edits
    b. Formatting and numbering
    c. Improved explanations

The Contextual Information and Resources document which will accompany the Standard of Practice does not require Council approval but is provided for informational purposes as *Appendix C*.

NOM – SofP – Practicing Medicine to Eliminate Anti-Indigenous Racism

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the Standard of Practice – Practicing Medicine to Eliminate anti-Indigenous Racism as presented to Council, and the coming into force of this Standard will be at a date set by Executive Committee.

As you review this document, please prioritize your mental health and well-being.

We recognize this topic may cause trauma or revoke memories of past harms experienced by First Nations, Inuit and Métis individuals. Support is available to those affected at The Indian Residential School Crisis Line: 1-866-925-4419 and Hope For Wellness Helpline: 1-855-242-3310, or online at hopeforwellness.ca

Survey Methodology

The consultation survey was open to all CPSM registrants, stakeholders, and the public.

The survey consisted of 10 questions which focused on:

- The principles of the Standard
- Clarity of the Standard
- Structure of the Standard

Survey respondents who identified themselves as CPSM registrants received an additional five questions (for a total of 15 questions) to collect opinions on:

- The importance of addressing anti-Indigenous racism in medical care
- Clarity of the obligations for CPSM registrants
- Confidence in their ability to apply the Standard in their practice
- Any barriers to applying the Standard (for CPSM registrants)
- Likeliness of being speaking up when witnessing anti-Indigenous racism

The first question determined which version of the survey respondents received; those who identified themselves as registrants received the second version of the survey.

Data collection period

CPSM registrants received a public consultation notice via email from the Registrar on October 9.

The consultation was launched to a list of Indigenous organizations via email on October 10. Other medical and healthcare partners, such as healthcare system leaders, the government, provincial regulatory bodies and medical regulatory authorities, as well as subscribers to CPSM's mailing list, were notified of the consultation via email on October 10.

The survey was open from October 8 to November 12, 2024 at noon on the SurveyMonkey platform.

Promotion

- CPSM registrants were encouraged to register for a webinar on October 23, hosted by Dr. Lisa Monkman, Chair of the CPSM Indigenous Advisory Circle and Dr. Ainslie Mihalchuk, Registrar and CEO, to learn more about the Standard and ask questions. The session was recorded and distributed to registrants. The webinar encouraged registrants to participate in the consultation.
- CPSM registrants were reminded of the consultation in the October newsletter on October 31.
- An email reminder notifying registrants there was one week left to submit feedback was sent on November 5.

- Indigenous organizations and medical and healthcare partners were also reminded of the deadline on November 5.
- A public notice of consultation was advertised in the Saturday, October 19 edition of the Winnipeg Free Press with a QR code linking to the consultation documents.
- A public notice of consultation was advertised in the October 23 editions of Grassroots News.

Total responses initiated: 84

Total responses completed: 48

Completion rate: 57%

Survey Response breakdown:

	Surveys Completed	**Surveys started but not completed**
Registrants	41	31
Non-registrants	7	5
Total	**48**	**36***

*Data was collected in 4 out of the 36 surveys that were started but not completed.

Data Analysis

Quantitative Data:

Six out of the 10 questions were quantitative. Responses were measured using a five-point Likert scale. The survey that CPSM registrants received included an additional five quantitative questions using a five-point Likert scale.

Of the 45 registrant survey responses 70% were positive overall and 30% were negative overall. Of the total 495 answers received 43% (213) were very positive, 21% (106) were positive, 8% (8%) were neutral, 11% (55) were negative, and 17% (84) were very negative (4 individuals were responsible for a third of the very negative responses).

Qualitative Data

Three questions in the registrant survey were qualitative and respondents asked to reflect on their opinions and experiences. For registrants, these questions required answering within their practice's context.

The responses cover a broad continuum from being very supportive to very negative. The above-mentioned negative commentators were typically longer and more vitriolic.

Other

- **Privacy considerations:** To encourage feedback and protect the privacy and confidentiality of survey participants, surveys were anonymous; respondents had the option of including their name and contact information if they chose to.
- **Other methods for collecting feedback**: email and phone lines available from October 8 to November 12, 2024, at noon. A toll-free phone line was available where people could leave a voice recording with their feedback. No feedback was received using this option.

Public Consultation – Practicing Medicine to Eliminate Anti-Indigenous Racism – **Non-registrant Survey Feedback**

The consultation survey was launched October 9.

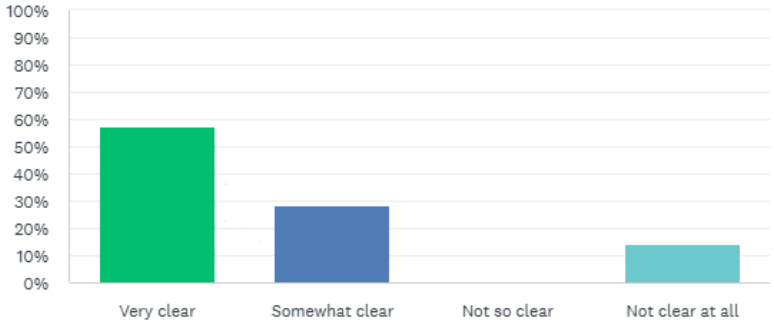
Designed in two different versions
Version#1: Public members, stakeholders, or other (questions 1-8, 21-24)
Version #2: CPSM Registrants (questions 9-24)

- A total of **84** surveys opened, with **48** submitted (completed)
- **36** surveys abandoned (incomplete)
- Of those completed, **41** are CPSM registrants, **7** non-registrants

Below is the data collected and compiled from the non-registrant copy survey.

Survey #5: None of the above
Survey #40: I am a member of the public (patient) residing in Manitoba
Survey #47: I am a member, employee, or representative of another regulated health profession in Manitoba
Survey #71: Other (please specify) : I am a practicing [redacted] of Indigenous Ancestry
Survey #77: I am a member of the public (patient) residing in Manitoba
Survey #79: I am a member of the public (patient) residing in Manitoba
Survey #83: Other (please specify): I am the wife of [redacted] who experienced racism and lack of care in the health care institutions in Winnipeg.

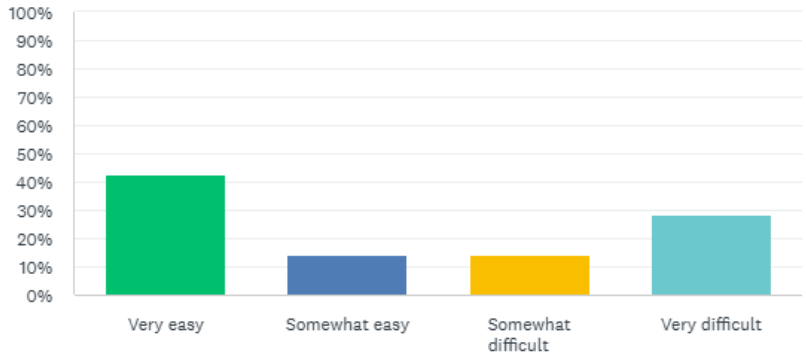
Q2: How clear was anti-Indigenous racism defined in the draft standard?



ANSWER CHOICES	RESPONSES	
Very clear	57.14%	4
Somewhat clear	28.57%	2
Not so clear	0.00%	0
Not clear at all	14.29%	1
TOTAL		7

Survey #5: Somewhat clear	**Survey #77:** Not clear at all
Survey#40: Very clear	**Survey #79:** Somewhat clear
Survey #47: Very clear	**Survey #83:** Very clear
Survey #71: Very clear	

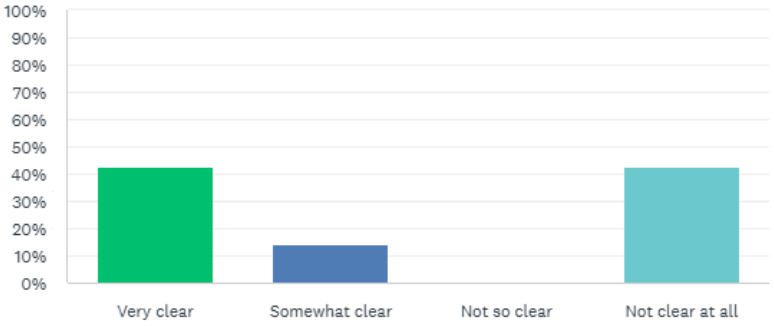
Q3: How easy or difficult was it to understand the draft Standard?



ANSWER CHOICES	RESPONSES	
Very easy	42.86%	3
Somewhat easy	14.29%	1
Somewhat difficult	14.29%	1
Very difficult	28.57%	2
TOTAL		7

Survey #5: Very difficult	**Survey #77:** Very difficult
Survey#40: Very easy	**Survey #79:** Somewhat difficult
Survey #47: Very easy	**Survey #83:** Somewhat easy
Survey #71: Very easy	

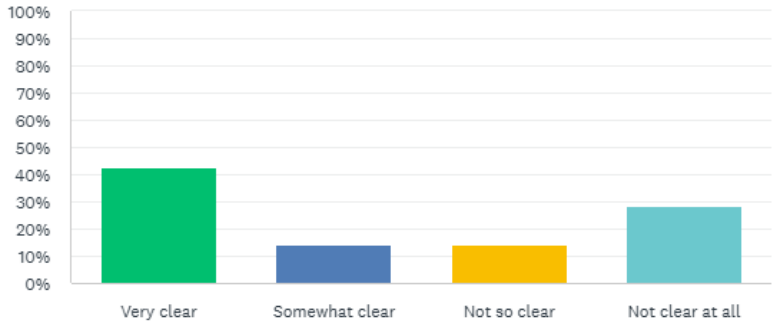
Q4: How clear was the guidance on understanding and identifying acts and omissions of anti-Indigenous racism?



ANSWER CHOICES	RESPONSES	
Very clear	42.86%	3
Somewhat clear	14.29%	1
Not so clear	0.00%	0
Not clear at all	42.86%	3
TOTAL		7

Survey #5: Not clear at all	**Survey #77:** Not clear at all
Survey#40: Very clear	**Survey #79:** Not clear at all
Survey #47: Very clear	**Survey #83:** Very clear
Survey #71: Somewhat clear	

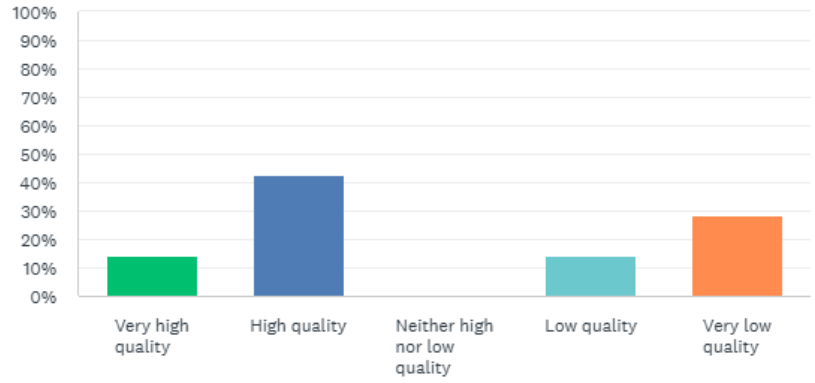
Q5: How clear was the guidance on taking action to address acts or omissions of anti-indigenous racism?



ANSWER CHOICES	RESPONSES	
Very clear	42.86%	3
Somewhat clear	14.29%	1
Not so clear	14.29%	1
Not clear at all	28.57%	2
TOTAL		7

Survey #5: Not clear at all	**Survey #77:** Not clear at all
Survey#40: Very clear	**Survey #79:** Not so clear
Survey #47: Very clear	**Survey #83:** Very clear
Survey #71: Somewhat clear	

Q6: How would you rate the quality of the draft Standard in addressing anti-Indigenous racism in medical care?



ANSWER CHOICES	RESPONSES	
Very high quality	14.29%	1
High quality	42.86%	3
Neither high nor low quality	0.00%	0
Low quality	14.29%	1
Very low quality	28.57%	2
TOTAL		7

Survey #5: Low quality	**Survey #77:** Very low quality
Survey#40: High quality	**Survey #79:** Very low quality
Survey #47: High quality	**Survey #83:** High quality
Survey #71: Very high quality	

Q7: Are there any gaps you think the Standard did not address? Please list them. (optional)

(3 out of the 7 responded)

Survey #5: Racism .....It is complex to understand. (but I must understand it to be a registrant?) What if a patient who is seeking emergency medical care calls me racist, what am I expected to do?
Survey #77: The proposed Standard of Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism by the College of Physicians and Surgeons of Manitoba (CPSM) is a commendable effort to address a critical issue within the healthcare system. However, while the intention behind the proposal is noble, there are several potential negative impacts that must be considered. This letter aims to highlight these concerns, emphasizing the need for a balanced approach that effectively tackles anti-Indigenous racism without compromising the quality of healthcare or the well-being of healthcare providers.

The introduction of specific standards aimed at eliminating anti-Indigenous racism could inadvertently lead to the stigmatization of Indigenous patients. By categorizing and treating Indigenous patients as a distinct group requiring different standards, there is a risk of reinforcing negative stereotypes and assumptions about their health and behavior. This could result in increased prejudice and discrimination, further marginalizing Indigenous patients rather than supporting them.

Implementing new standards requires significant changes in practice, training, and resource allocation. There is a concern that the CPSM may not have adequately planned for these challenges, leading to inconsistent application of the standards across different healthcare settings. Without proper training and resources, healthcare providers may struggle to meet the new requirements, resulting in suboptimal care for Indigenous patients.

Trust is a fundamental component of the patient-physician relationship. The introduction of new standards, particularly those perceived as punitive, could damage this trust. Physicians may feel pressured to adhere strictly to the standards, potentially leading to a more rigid and less empathetic approach to patient care. This could alienate both Indigenous and non-Indigenous patients, reducing the overall quality of care.

The focus on eliminating anti-Indigenous racism, while important, could divert attention from other critical aspects of patient care. Healthcare providers may become overwhelmed by the additional requirements, leading to burnout and reduced quality of care. It is essential to strike a balance that addresses racism without compromising other essential elements of healthcare delivery.

The proposed standards are likely to involve additional documentation, reporting, and compliance measures. This increased administrative burden can be particularly challenging for already overworked healthcare providers. Time spent on administrative tasks could detract from the time available for direct patient care, potentially leading to longer wait times and reduced patient satisfaction.

The threat of punitive measures for non-compliance with the standards may create a culture of fear and defensiveness among healthcare providers. Instead of fostering an environment of open dialogue and continuous improvement, there is a risk that physicians may become more focused on avoiding penalties rather than genuinely addressing the root causes of racism.

The healthcare system is already under significant strain, with many providers experiencing burnout and high levels of stress. The introduction of new standards, particularly those that require substantial changes in practice, could exacerbate these issues. It is crucial to consider the well-being of healthcare providers to ensure they can continue to deliver high-quality care.

The additional demands and perceived punitive nature of the proposed standards could deter new healthcare professionals from entering the field and encourage existing providers to leave. This could lead to staffing shortages and increased pressure on those who remain, further compromising the quality of care.

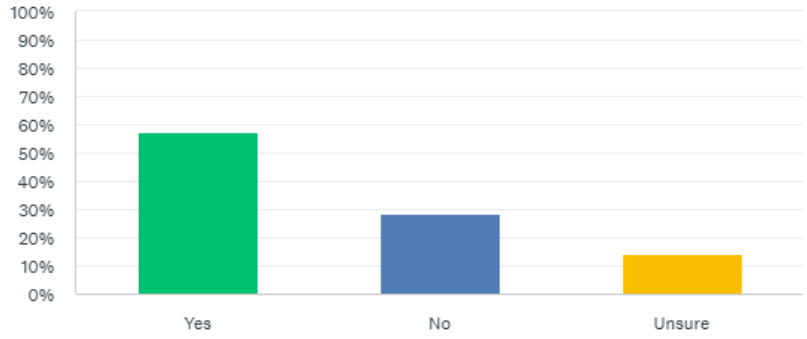
The implementation of the proposed standards could have broader societal implications, particularly in terms of how healthcare is perceived by the public. If the standards are viewed as controversial or divisive, there is a risk of further polarization on issues of race. It is essential to engage in a broader dialogue with the community to build consensus and support for the proposed changes.

Any significant change, particularly one that addresses sensitive issues like racism, can provoke backlash. There is a risk that the proposed standards could lead to resistance from both healthcare providers and the public. It is important to anticipate and address these concerns to ensure the successful implementation of the standards.

Trust between Indigenous communities and healthcare providers is already fragile. The proposed standards, if not implemented thoughtfully, could either strengthen or further erode this trust. Engaging Indigenous communities in the development and implementation of the standards is crucial to ensure they are effective and culturally appropriate.
The proposed standards may have legal implications for healthcare providers. There is a need to carefully consider how the standards align with existing laws and regulations to avoid potential legal challenges. Healthcare providers must be provided with clear guidance on how to comply with the standards without risking legal repercussions.
The introduction of specific standards to address anti-Indigenous racism raises several ethical questions. Healthcare providers must balance the need for cultural competence with the principles of equality and fairness. It is important to ensure that the standards do not inadvertently create new forms of discrimination or inequality.
While accountability is essential, it is equally important to ensure that healthcare providers are treated fairly. The proposed standards should emphasize support and education rather than punitive measures. By fostering a culture of learning and improvement, healthcare providers can better address the underlying issues of racism.
Instead of introducing rigid standards, consider alternative approaches that promote cultural competence and understanding. This could include more comprehensive training programs, community engagement initiatives, and collaboration with Indigenous organizations.
Engage Indigenous communities in the development and implementation of the standards. By involving those who are directly affected, the CPSM can ensure that the standards are culturally appropriate and effectively address the unique needs of Indigenous patients.
Emphasize the importance of cultural competence training for all healthcare providers. This training should be ongoing and integrated into all aspects of medical education and practice. By enhancing cultural competence, healthcare providers can deliver more equitable and respectful care.
Develop clear metrics to measure and evaluate the impact of the proposed standards. Regular assessments and feedback can help identify areas for improvement and ensure that the standards are achieving their intended goals.
Being accused of racism, particularly in a high-stakes environment like healthcare, can severely damage a physician’s morale and professional reputation. Such accusations, whether founded or not, can undermine a physician's confidence and trust in their interactions with patients. This may lead to hesitation and second-guessing in clinical decision-making, ultimately affecting the quality of care provided.
Physicians may become overly cautious and defer to patient demands, even when these demands may not align with medical best practices, due to fear of being labeled racist. This can result in compromised medical judgment and decision-making, where the primary goal is to avoid conflict rather than provide the best possible care. In the long term, this dynamic could degrade the overall standard of medical practice.
Accusations of racism can create a strained and adversarial relationship between the physician and the patient. This strain can hinder effective communication, which is essential for accurate diagnosis and treatment. The mutual respect and understanding needed for a collaborative patient-physician relationship may be eroded, leading to less effective healthcare outcomes.
Constantly being under the threat of accusations can take an emotional and psychological toll on physicians. The stress and anxiety associated with such accusations can contribute to burnout, which is already a significant issue in the healthcare profession. This can decrease job satisfaction and increase turnover rates among healthcare providers.

Physicians who are frequently accused of racism might find themselves professionally isolated, either through self-imposed withdrawal or ostracization by their peers. This isolation can limit opportunities for professional development, mentorship, and peer support, which are crucial for maintaining high standards of care and continuous improvement. Accusations of racism can lead to legal actions and professional disciplinary measures. Even if accusations are unfounded, the process of defending oneself can be time-consuming, stressful, and financially draining. The professional stigma associated with such accusations can also have long-lasting effects on a physician's career and future employment opportunities. Physicians may feel their clinical autonomy is compromised if they must frequently alter their clinical decisions to avoid accusations of racism. This could lead to a practice environment where medical decisions are driven by fear rather than evidence-based medicine, ultimately impacting patient care quality and safety. Addressing anti-Indigenous racism in healthcare is a critical and urgent issue. While the CPSM's proposed Standard of Practice aims to address this problem, it is essential to carefully consider the potential negative impacts and challenges associated with its implementation. By adopting a balanced and thoughtful approach, engaging with Indigenous communities, and focusing on support and education, we can work towards a healthcare system that is truly equitable and inclusive for all.
Survey #83: The Standard is written at a broad and high level that may obscure the intensity and causality of specific and direct patient interactions and experiences. By contrast, the Contextual Information points directly to behaviours that could and should be specified in the Standard itself.

Q8: Did you find the structure of the standard effective? (i.e. three steps)



ANSWER CHOICES	RESPONSES	
Yes	57.14%	4
No	28.57%	2
Unsure	14.29%	1
TOTAL		7

Survey #5: Unsure	**Survey #77:** No
Survey#40: Yes	**Survey #79:** No
Survey #47: Yes	**Survey #83:** Yes
Survey #71: Yes	

Q21: Do you have recommendations for improving the standard? (optional)

Survey #71: I think the standard is a great start, having it be a living document that can be added to or modified in future once implemented makes it a great template.
Survey #77: *answered this question with the same answer to Q7*
Survey #79: So, which is it? How are you going to acknowledge and take responsibility if you don't recognize the unique ways indigenous people suffer? Alcoholism is a stereotype because of colonialism. You can't take responsibility while also pretending there isn't an issue.
Survey #83: The evidence in contextual information, particularly the experiences expressed in the SCO consultation document, is exactly the experiential language that the Standard should incorporate. The feedback request itself states: "..these perspectives and lived experiences are essential to enhancing the standard of practice." They could and should be cited more directly in the standard.

Q22: Do you have any other comments regarding the standard? (optional)

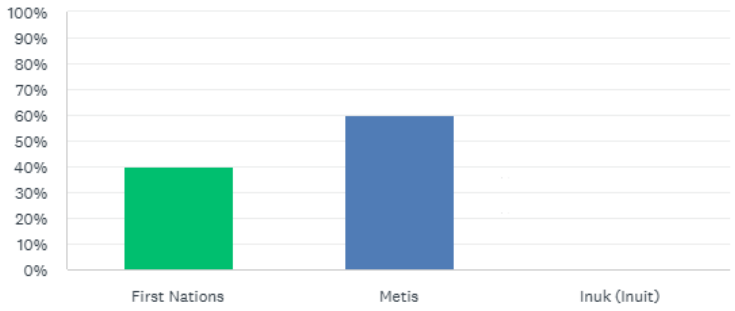
(4 out of the 7 responded)

Survey #40: The standard itself is great, as it's much needed. What I worry about are the supports around the standard: 1) the development and requirement for education and training for all doctors, not just those in medical school, that is appropriate to their level, understanding that they will have a vast difference in prior knowledge around the histories and realities of Indigenous peoples in the territory currently known as Canada; and 2) enforcement. How will the College ensure that all doctors have sufficient education to understand and adhere to this standard? What are the penalties if a doctor chooses not to take training? Is training mandatory? Who is overseeing doctors' behaviour in response to the standard?
Survey #71: As a [redacted] working on our own Reconciliation action plan, I found your document very encouraging, especially by not laying individual blame but collective agreement that the treatment of Indigenous patient has fallen short, and this is a plan to make things better is a great way to start.
Survey #79: This survey. Your asking if I identify as indigenous is racist and hypocritical. Your explanation as to why you collect this information is suspiciously vague. Does my opinion matter more or less to you depending on my identification? Either you treat me like everybody else or just be honest that you're not going to.
Survey #83: In mid-2023, I participated with [redacted] by providing testimony for the modules developed for [redacted]. I didn't see all the modules, but the intention was parallel to this current work. I provided written text and video-recorded narrative of specific experiences of a residential school survivor, my husband, in dealing with primary care,

emergency services, four hospitals and end of life experience. This information was submitted to [redacted]. I understand now that the modules may not have been reviewed, put into practice or reviewed in the development of this Standard of Practice. I would appreciate receiving a response on this point. It was a very grueling and emotionally exhausting effort to provide that first hand testimony both in writing and by video-recording. I also have pursued those experiences through [redacted], engaging in many hours of oral and written documentation for their purposes of practitioner education. I can't say whether any of these efforts have impacted the individual or systemic problems that the Standard seeks to address. I note that question 12 below does not give me the choice to self-identify as a non-Indigenous person married for 45 years to a First Nations residential school survivor, community leader and Elder, whose experiences are documented and will never be forgotten.

Q24: Do you identify as any of the following? (optional) Why are we asking this? Data is important for illuminating gaps in medical care. The feedback you shared will help us address anti-Indigenous racism and discrimination. The more we understand about you, the better we can learn and enable change.

2 out of 7 non-registrant respondents answered.



ANSWER CHOICES	RESPONSES	
First Nations	40.00%	2
Metis	60.00%	3
Inuk (Inuit)	0.00%	0
Total Respondents: 5		

Survey #71: First Nations

Survey #77: First Nations

Public Consultation – Practicing Medicine to Eliminate Anti-Indigenous Racism - **Registrant Survey Feedback**

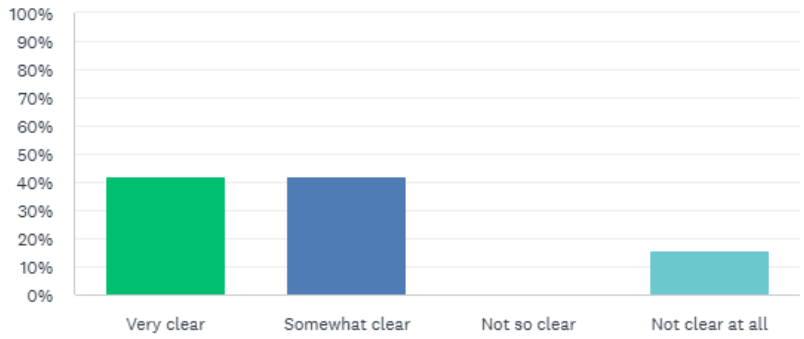
The consultation survey was launched October 9.

Designed in two different versions
Version#1: Public members, stakeholders, or other (questions 1-8, 21-24)
Version #2: CPSM Registrants (questions 9-24)

- A total of **84** surveys opened, with **48** submitted (completed)
- **36** surveys abandoned (incomplete)
- Of those completed, **41** are CPSM registrants, **7** non-registrants

Below is the data collected and compiled from the Registrant copy survey.
* Total of 41 respondents (completed), 4 respondents feedback collected, however, abandoned midway explaining 45 total answered. Survey Monkey is designed to collect all data whether or not the survey is completed.

Q9: How clear was anti-Indigenous racism defined in the draft standard?

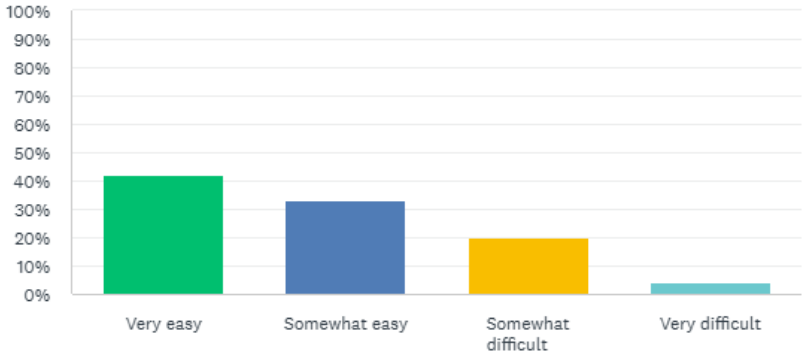


ANSWER CHOICES	RESPONSES	
Very clear	42.22%	19
Somewhat clear	42.22%	19
Not so clear	0.00%	0
Not clear at all	15.56%	7
TOTAL		45

Survey #10: very clear	**Survey #51:** very clear
Survey #12: not clear at all	**Survey #53:** somewhat clear
Survey #13: somewhat clear	**Survey #54:** very clear
Survey #16: very clear	**Survey #55:** very clear
Survey #18: very clear	**Survey #56:** very clear
Survey #20: somewhat clear	**Survey #57:** somewhat clear
***Survey #23:** somewhat clear	***Survey #58:** somewhat clear
Survey # 24: somewhat clear	**Survey #59:** not clear at all
Survey #25: very clear	**Survey #62:** somewhat clear
Survey #27: somewhat clear	**Survey #63:** somewhat clear
***Survey #28:** not clear at all	**Survey #65:** not clear at all
Survey #29: very clear	**Survey #67:** very clear

Survey #31: somewhat clear	**Survey #68:** very clear
Survey #32: very clear	**Survey #72:** somewhat clear
Survey #34: very clear	**Survey #73:** somewhat clear
Survey #35: somewhat clear	**Survey #74:** very clear
Survey #37: somewhat clear	**Survey #75:** very clear
Survey #38: somewhat clear	***Survey #76:** very clear
Survey #39: very clear	**Survey #78:** somewhat clear
Survey#42: not clear at all	**Survey #80:** somewhat clear
Survey #44: somewhat clear	**Survey #82:** very clear
Survey #45: not clear at all	**Survey #84:** not clear at all
Survey #48: very clear	

Q10: How easy or difficult was it to understand the draft Standard?

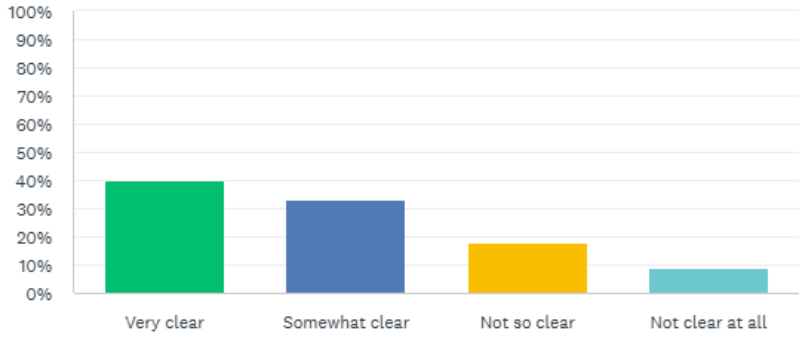


ANSWER CHOICES	RESPONSES	
Very easy	42.22%	19
Somewhat easy	33.33%	15
Somewhat difficult	20.00%	9
Very difficult	4.44%	2
TOTAL		45

Survey #10: very easy	**Survey #51:** very easy
Survey #12: somewhat difficult	**Survey #53:** somewhat easy
Survey #13: somewhat difficult	**Survey #54:** very easy
Survey #16: very easy	**Survey #55:** very easy
Survey #18: very easy	**Survey #56:** very easy
Survey #20: somewhat difficult	**Survey #57:** very easy
***Survey #23:** somewhat easy	***Survey #58:** somewhat easy
Survey # 24: somewhat difficult	**Survey #59:** somewhat easy
Survey #25: very easy	**Survey #62:** somewhat easy
Survey #27: somewhat easy	**Survey #63:** somewhat easy
***Survey #28:** somewhat difficult	**Survey #65:** somewhat difficult
Survey #29: very easy	**Survey #67:** very easy
Survey #31: somewhat easy	**Survey #68:** somewhat easy

Survey #32: very easy	**Survey #72:** somewhat difficult
Survey #34: very easy	**Survey #73:** somewhat easy
Survey #35: somewhat difficult	**Survey #74:** very easy
Survey #37: very easy	**Survey #75:** somewhat easy
Survey #38: very easy	***Survey #76:** very easy
Survey #39: somewhat easy	**Survey #78:** very easy
Survey#42: very difficult	**Survey #80:** somewhat easy
Survey #44: somewhat easy	**Survey #82:** very easy
Survey #45: somewhat difficult	**Survey #84:** very difficult
Survey #48: somewhat easy	

Q11: How clear was the guidance on understanding and identifying acts and omissions of anti-Indigenous racism?

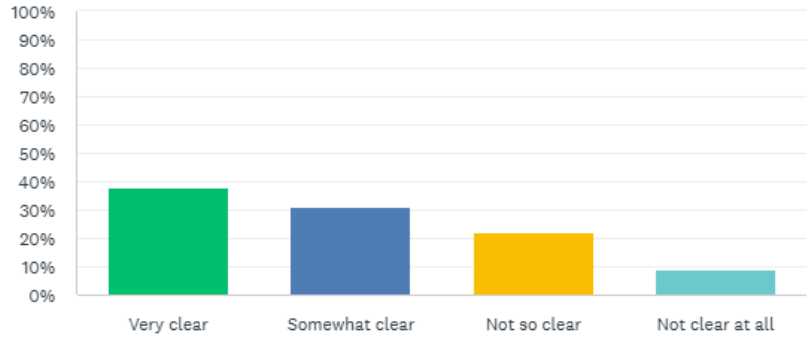


ANSWER CHOICES	RESPONSES	
Very clear	40.00%	18
Somewhat clear	33.33%	15
Not so clear	17.78%	8
Not clear at all	8.89%	4
TOTAL		45

Survey #10: very clear	**Survey #51:** very clear
Survey #12: not clear at all	**Survey #53:** somewhat clear
Survey #13: not so clear	**Survey #54:** very clear
Survey #16: very clear	**Survey #55:** somewhat clear
Survey #18: very clear	**Survey #56:** very clear
Survey #20: not so clear	**Survey #57:** somewhat clear
***Survey #23:** somewhat clear	***Survey #58:** somewhat clear
Survey # 24: not so clear	**Survey #59:** not so clear
Survey #25: very clear	**Survey #62:** very clear
Survey #27: somewhat clear	**Survey #63:** somewhat clear
***Survey #28:** not clear at all	**Survey #65:** not so clear
Survey #29: very clear	**Survey #67:** very clear
Survey #31: very clear	**Survey #68:** somewhat clear
Survey #32: very clear	**Survey #72:** not so clear

Survey #34: very clear	**Survey #73:** somewhat clear
Survey #35: not so clear	**Survey #74:** very clear
Survey #37: somewhat clear	**Survey #75:** very clear
Survey #38: very clear	***Survey #76:** very clear
Survey #39: very clear	**Survey #78:** somewhat clear
Survey#42: not clear at all	**Survey #80:** somewhat clear
Survey #44: somewhat clear	**Survey #82:** somewhat clear
Survey #45: not so clear	**Survey #84:** not clear at all
Survey #48: somewhat clear	

Q12: How clear was the guidance on taking action to address acts or omissions of anti-indigenous racism?

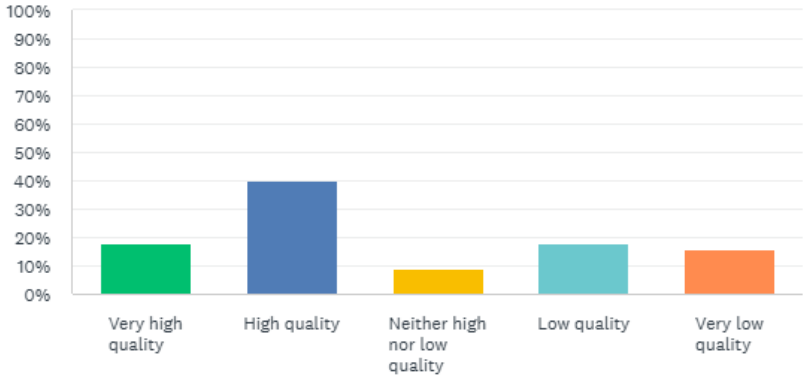


ANSWER CHOICES	RESPONSES	
Very clear	37.78%	17
Somewhat clear	31.11%	14
Not so clear	22.22%	10
Not clear at all	8.89%	4
TOTAL		45

Survey #10: somewhat clear	**Survey #51:** very clear
Survey #12: not so clear	**Survey #53:** somewhat clear
Survey #13: not so clear	**Survey #54:** very clear
Survey #16: very clear	**Survey #55:** somewhat clear
Survey #18: very clear	**Survey #56:** very clear
Survey #20: not so clear	**Survey #57:** somewhat clear
***Survey #23:** somewhat clear	***Survey #58:** not so clear
Survey # 24: not so clear	**Survey #59:** not so clear
Survey #25: somewhat clear	**Survey #62:** somewhat clear
Survey #27: somewhat clear	**Survey #63:** somewhat clear
***Survey #28:** not clear at all	**Survey #65:** not so clear
Survey #29: very clear	**Survey #67:** very clear
Survey #31: very clear	**Survey #68:** not so clear
Survey #32: very clear	**Survey #72:** not so clear

Survey #34: very clear	**Survey #73:** somewhat clear
Survey #35: not clear at all	**Survey #74:** very clear
Survey #37: somewhat clear	**Survey #75:** somewhat clear
Survey #38: very clear	***Survey #76:** very clear
Survey #39: very clear	**Survey #78:** very clear
Survey#42: not clear at all	**Survey #80:** somewhat clear
Survey #44: very clear	**Survey #82:** somewhat clear
Survey #45: not so clear	**Survey #84:** not clear at all
Survey #48: very clear	

Q13: How would you rate the quality of the draft Standard in addressing anti-Indigenous racism in medical care?



ANSWER CHOICES	RESPONSES	
Very high quality	17.78%	8
High quality	40.00%	18
Neither high nor low quality	8.89%	4
Low quality	17.78%	8
Very low quality	15.56%	7
TOTAL		45

Survey #10: high quality	**Survey #51:** high quality
Survey #12: low quality	**Survey #53:** low quality
Survey #13: very low quality	**Survey #54:** high quality
Survey #16: very high quality	**Survey #55:** high quality
Survey #18: very high quality	**Survey #56:** very high quality
Survey #20: low quality	**Survey #57:** neither high nor low quality
***Survey #23:** high quality	***Survey #58:** low quality
Survey # 24: high quality	**Survey #59:** very low quality
Survey #25: high quality	**Survey #62:** high quality
Survey #27: very low quality	**Survey #63:** high quality
***Survey #28:** very low quality	**Survey #65:** low quality
Survey #29: very high quality	**Survey #67:** very high quality

Survey #31: high quality	**Survey #68:** very high quality
Survey #32: very high quality	**Survey #72:** neither high nor low quality
Survey #34: high quality	**Survey #73:** high quality
Survey #35: low quality	**Survey #74:** high quality
Survey #37: very low quality	**Survey #75:** neither high nor low quality
Survey #38: low quality	***Survey #76:** very high quality
Survey #39: high quality	**Survey #78:** high quality
Survey#42: very low quality	**Survey #80:** neither high nor low quality
Survey #44: high quality	**Survey #82:** high quality
Survey #45: low quality	**Survey #84:** very low quality
Survey #48: high quality	

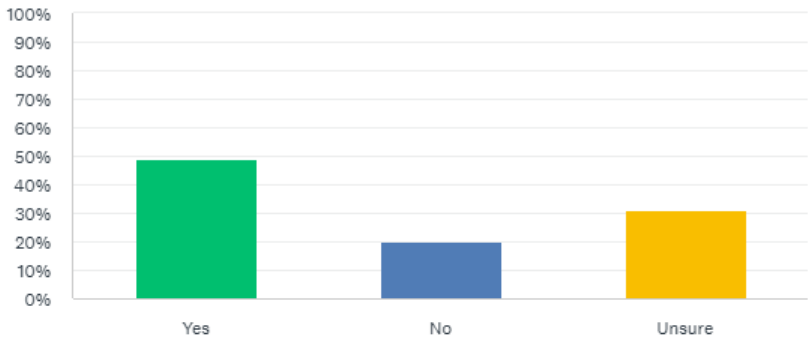
Additional feedback/comments to Q13. See below.

Survey #10: Are we going to develop a similar protocol for racism in all forms? 2. Institutional racism is particularly difficult to detect and difficult with which to deal and even more frequent than individual racism!
Survey #12: Starting the discussion by asserting that "racism has many definitions. It is simultaneously simple and complex to understand" does not help to operationalize a clear and actionable definition of racism. Stating that racism "results in harmful acts or omissions" and that "it is the impacts of these acts or omissions that need to be recognized and addressed" contradicts the later statement that "racism [itself] is a form of harm." Does the standard require registrants to be compliant in their personal opinions, their professional behaviors, or both? A final point of semantics - "Anti-Indigenous racism" is not defined in the standard - "Indigenous-specific racism" is.
Survey #16: It was not clear how much consultation with Indigenous CPSM members and partners has taken place in the creation of this draft. I am also not aware of what the Restorative Practices Program is which is referenced in the draft - should this be added to the definitions section? How does CPSM define "restorative practices"?
Survey #18: Page 3 suggestions: 1. Change the word "compliance" to "adherence" 2. Change "...when articulating their needs for care." to "...when requiring care." Because many times patients cannot, or have trouble, articulating their needs
Survey #37: Grouping people by their genetic similarities is a racist operation. The fact that it is spearheaded by indigenous people does not change that fact. I believe that we should focus on helping those in need, and if indigenous people are disproportionally represented in that group, then they will be disproportionately helped.
Survey #38: parts of the content are conflicting and pedantic
Survey #42: While I appreciate the sentiment, I see this as an overly political document that is well beyond the purview of the CPSM. The CPSM should be politically neutral, and it is quite possible to have a strong policy against racist actions without taking a political position. This document, authored

by a group chaired by the wife of a sitting NDP premier, uses a lot of coded language favoured by the far-left and makes several overtly political statements that are not grounded in evidence. For just one example, the "Concepts that Must be Understood by Registrants" is filled with opinions rather than facts - made explicit by the lack of any citations for some of the wild claims contained therein. Racism absolutely exists in health care but trying to gaslight people into believing that our present-day health care system is deeply systemically racist, or that our evidence-based practice that grew out of colonialism is a bad thing, is not what I would expect from an organization like the CPSM. To be clear, I am absolutely committed to tolerance and respect for all people and cultures, but I also believe in evidence and science. That is why I am in medicine. The "definition" of racism in this document is absurdly broad, and the encouragement to "report" on other members for perceived infractions is deeply troubling. Your document states that "failing to demonstrate interest in Indigenous teachings" is racist. It also implies that the factual acknowledgement that traditional Indigenous healing practices are not as efficacious as evidence-based medicine is racist (if this is not in fact the intent of the document, it desperately needs to be clarified). One can respect a patient's autonomy and choices regarding their care while at the same time recognizing that culturally-based health practices are for the most part placebo care. You state that we could be reported for not seeking "ongoing education" in Indigenous culture - really? If that is not the intent of the paper, it needs to be clarified. The section entitled "Take Action to Address Acts or Omissions of Anti-Indigenous Racism" gives one the strong impression that opposition to provincial NDP social policies would put one at risk of being reported to the college for being racist. It is not racist to believe that reckless spending on programs not grounded in evidence is inappropriate. I am left with the strong impression that this is a politically motivated document meant to align the CPSM with provincial NDP policy and explicitly threaten any member who might disagree with that policy. The document's scope extends well beyond that of racism into areas that the CPSM should remain neutral on, and creates a dystopian environment where members could easily report others who are not sufficiently politically leftist. The current Code of Ethics adequately addresses racism and this very flawed document should not be adopted. If you do decide to rewrite it, the CPSM also needs to be aware of modern concepts of conflict of interest which were clearly not followed here.
Survey #48: the 4th bullet on pg 9 of the standard seems to be missing a word - it doesn't say what you are allowing the mentioned people to do.
Survey #55: There should be clear protocol like a b c or steps.. to address ,to report and what to expect. Presently working physicians also are vulnerable to false complaints by the patients based on bad experiences of past which they never reported. How physician should handle that situation and whom to report abusive language or behavour of first nation patients. Even threats of false complaints against doctord to the College are very stressful to handle by physicians. CPSM should give guidelines on that too
Survey #72: I think some of the statements are too broad and presumptive.
Survey #84: The draft Standard has greater resemblence to a political manifesto rather than a dispassionate regulatory guileline or procedure from an supposedly apolitical body. The definitions offered are imprecise and poorly written, laced with editorialized language revealing of an radical political stance. The content is also disorganized, with subjective political statement shoehorned throughout. Below are a number of specific conerns: 1. Regarding Question 2 of this survey, although pedantic, no definition of "anti-Indigenous racism" is offered in the Standard. 2. On

page 2 of the draft Standard states, "...we are working within a racist system...", and on page 3, it states, "...the present exists upon colonial and racist foundations." These are highly controversial political statements and must not be codified as fact by the apolitical CPSM. 3. The draft Standard creates a NEW duty to report "racist behaviour or systemic racism regardless of whether the act or omission was caused by a registrant or someone else or some organization". There are a few problems with this: a) Jurisdiction. The CPSM does not have any authority to regulate the behaviours of non-registrants. This draft Standard should not attempt to regulate any person or institution over which it has no jurisdictional authority. b) The draft Standard states as a matter of fact that "...we are working within a racist system...", and that "...the present exists upon colonial and racist foundations.", then goes on to create a duty to report systemic racism. If registrants are required to adopt those beliefs, then they must continuously report "the system" and "the present" to the Restorative Practices Program, as they are, by definition (according to the CPSM), racist. This is illogical and makes it impossible for any registrant to satisfy the requirements of this Standard as written. At minimum, the CPSM should withdraw the "duty" to report, and make it a non-requriement (e.g., "may report") 4. Concerningly, the draft Standard articulates no guarantees of due process or protections for the accused relating to complaints made to the Restorative Practices Program. The lack of such basic aspects of fairness and justice are wholly unacceptable, and creates risks for the CPSM and its registrants. In legal circles, restorative justice and practices must be preceded by an impartial and fair determination of guilt or innocence. The method of determination of guilt or innocence is entirely lacking in this draft Standard, which leads me to believe that guilt will be assumed by the CPSM when a report of racism is lodged. While it may be nice to believe that all complainants act in good faith, that is simply and sadly not true. There must be some protections for the accused. It is not sufficient to say that a registrant must remediate by virtue of their being a complaint. Remediation in the face of a false complaint is the opposite of justice. 5. The CPSM seems to be confused about the nature of this draft Standard. In an email to registrants (Oct 9th), the CPSM described the draft Standard as "...a mechanism for proactively educating registratns on what anti-Indigensous racism is...", yet reading the draft Standard, it is largely about responding to reports of racisms in a reactive manner. 6. In the same email to registrants (Oct 9th), the CPSM also states that implementation of the Standard will "...allow registrants to learn and grow without the fear of discipline", yet the CPSM website (https://cpsm.mb.ca/news/public-consultation-eliminating-anti-indigenous-racism) states that it will "...allow for learning and growth without the fear of immediate discipline". The deletion of the word "immediate" in the email to registrants entirely changed the meaning of the statement and appears to have been done to mislead registrants. Any reasonable person would agree that any discipline is feared, not only that which is immediate. The CPSM needs to make explicit under what circumstances and with what protections of due process will discipline be meted out to registrants, whether it is "immediate" or not.

Q14: Did you find the structure of the standard effective? (i.e. three steps)



ANSWER CHOICES	RESPONSES	
Yes	48.89%	22
No	20.00%	9
Unsure	31.11%	14
TOTAL		45

Survey #10: unsure	**Survey #51:** yes
Survey #12: unsure	**Survey #53:** no
Survey #13: no	**Survey #54:** yes
Survey #16: yes	**Survey #55:** unsure
Survey #18: yes	**Survey #56:** yes
Survey #20: no	**Survey #57:** unsure
***Survey #23:** yes	***Survey #58:** unsure
Survey # 24: yes	**Survey #59:** no
Survey #25: yes	**Survey #62:** yes
Survey #27: no	**Survey #63:** yes
***Survey #28:** no	**Survey #65:** unsure
Survey #29: yes	**Survey #67:** yes
Survey #31: yes	**Survey #68:** unsure
Survey #32: yes	**Survey #72:** unsure
Survey #34: yes	**Survey #73:** yes
Survey #35: unsure	**Survey #74:** yes
Survey #37: unsure	**Survey #75:** yes
Survey #38: no	***Survey #76:** yes
Survey #39: yes	**Survey #78:** yes
Survey#42: no	**Survey #80:** unsure
Survey #44: yes	**Survey #82:** unsure
Survey #45: unsure	**Survey #84:** no
Survey #48: unsure	

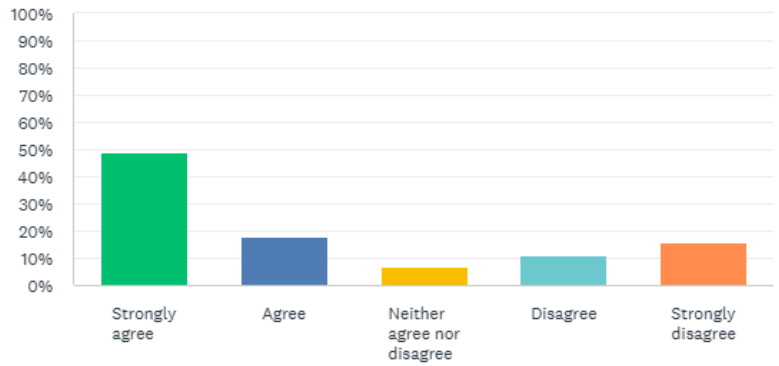
Q15: Are there any gaps you think the Standard did not address? Please list them. (optional)

Feedback/comments below.

Survey #10: Yes How to deal with institutional issues safely!
Survey #12: It is important for the College to recognize its own institutional position of privilege. As a professional regulator, the College has power over both its registrants and the public. It should approach its regulatory duty from a position of humility, being cautious not to overstep the limits of its knowledge regarding systemic challenges faced by registrants attempting to provide care and the concrete resource limitations faced by indigenous communities. The tone of this draft comes across as a pledge by the College to enforce equitable care across a province where absolute financial and logistical considerations (i.e. access to facilities and supplies, road access to communities, medevac availability, et cetera) preclude genuine equity. This sets up the indigenous public to be on the receiving end of another false promise. The College should explicitly recognize that applying the same standards of care across the province and profession irrespective of geography leads to unintended consequences. Care that can be argued to otherwise provide a net benefit (eg. obstetrics) is often unavailable in remote locations because it cannot be provided at the required level of absolute safety. The College should also reduce barriers to the provision of complementary and alternative modalities. This would serve to destigmatize learning about traditional healing by registrants. Such steps may also encourage the incorporation of traditional healing practices in patient care when appropriate.
Survey #16: Definition of "restorative practices"?
Survey #18: Race is a social construct. I am not sure if you want to say that. The fact that it is a social construct rather than a clear biologic entity does not mean that racism does not exist, it just means that human beings see and judge others according to a social idea that they hold to be true and real. I personally think this is important for people to understand…that they are making judgements about a perception that is not even real, but maybe you don't want to, or need to, get into this.
Survey #25: Where is the Reporting Body? Who is overseeing it?
Survey #37: I do not believe there should be any standards of Practice Targeting a specific group, but for all Canadians citizens. For one, racism is a political term and often misunderstood. One cannot talk about racism if they do not also talk about generalizations, prejudice, tribalism, and stigma. Many accusations of racism are often simple, generalizations, sometimes competition between groups, and sometimes just simply stigma -Often perpetrated by the downtrodden group themselves.
Survey #38: Correctly address the definition of Racism. For example the draft states: "Racism has many definitions. It is simultaneously simple and complex to understand". Racism does not have many definitions and is not complex to understand. If the author(s) of this draft thinks so I suggest they consult a dictionary. For their benefit I have include the definition from arguably the authority of the English Language, the Oxford English Dictionary: Prejudice, antagonism, or discrimination by an individual, institution, or society, against a person or people on the basis of their nationality or (now usually) their membership of a particular racial or ethnic group, typically one that is a minority or marginalized. Also: beliefs that members of a particular racial or ethnic group

possess innate characteristics or qualities, or that some racial or ethnic groups are superior to others; an ideology based on such beliefs. Cf. racialism n. Secondly, integrity and adherence to ethical practise versus recommended behavior in this document is in conflict. The code of ethics in the draft is quoted as: 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. yet the document also states: 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 scientific medicine. and yet later the draft states: 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. I think to recommend or trust "traditional" medicine as genuine is unethical. I will not agree or promote a medical practise that is not evidence based. For example, i have had patients that choose to treat their cancer with "traditional medicine". By supporting this type of treatment I would be in conflict with the code of ethics as noted above: 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. Supporting an unproven form of treatment does not demonstrate safety, competence nor integrity. In fact it does a disservice to the patient by offering false hope and brings the physician in conflict again with his or her ethical responsibilities as noted: Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient. To achieve this we must agree not to promote or accept unproven and therefore harmful forms of treatment including traditional medicine.
Survey #42: No, the document is overly broad.
Survey #53: Having a standard against anti indigenous racism is good however we need to have standards to address racism in general. Not just against one specific population. I think this is a huge gap. The standard also doesn't address the gap in health literary and how it's our duty to ensure all our patients are empowered regarding their health.
Survey #68: No gaps
Survey #80: MUTUAL RESPONSIBILITY & COMITTMENT FROM HEALTH CARE PROVIDER / PATIENT / SUPPORT SYSTEM OF THE PATIENT (THE BAND, SPIRITUAL PERSONEL) TO PROVIDE THE BEST HEALTH SERVICE
Survey #82: -make it more clear who/where to report to, resource with possible reporting pathways/contacts/organizations - more resources/list for ways to access more information/education re colonization, mb history etc

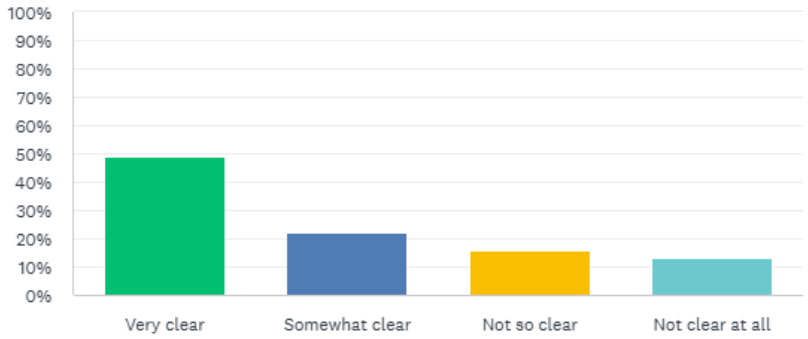
Q16: Do you agree or disagree with the following statement: As a medical regulator, CPSM has a duty to educate the medical profession on what anti-Indigenous racism looks like, how to identify it, and how to eliminate it.



ANSWER CHOICES	RESPONSES	
Strongly agree	48.89%	22
Agree	17.78%	8
Neither agree nor disagree	6.67%	3
Disagree	11.11%	5
Strongly disagree	15.56%	7
TOTAL		45

Survey #10: strongly agree	**Survey #51:** strongly agree
Survey #12: disagree	**Survey #53:** neither agree nor disagree
Survey #13: strongly disagree	**Survey #54:** agree
Survey #16: strongly agree	**Survey #55:** agree
Survey #18: strongly agree	**Survey #56:** strongly agree
Survey #20: disagree	**Survey #57:** agree
***Survey #23:** strongly agree	***Survey #58:** disagree
Survey # 24: strongly agree	**Survey #59:** strongly disagree
Survey #25: strongly agree	**Survey #62:** strongly agree
Survey #27: strongly disagree	**Survey #63:** strongly agree
***Survey #28:** strongly disagree	**Survey #65:** agree
Survey #29: strongly agree	**Survey #67:** strongly agree
Survey #31: strongly agree	**Survey #68:** strongly agree
Survey #32: strongly agree	**Survey #72:** neither agree nor disagree
Survey #34: strongly agree	**Survey #73:** strongly agree
Survey #35: strongly disagree	**Survey #74:** agree
Survey #37: disagree	**Survey #75:** strongly agree
Survey #38: neither agree nor disagree	***Survey #76:** strongly agree
Survey #39: agree	**Survey #78:** strongly agree
Survey#42: strongly disagree	**Survey #80:** agree
Survey #44: agree	**Survey #82:** strongly agree
Survey #45: disagree	**Survey #84:** strongly disagree
Survey #48: strongly agree	

Q17: How clearly does the draft standard outline your obligations as a CSPM registrant to ensure anti-racism in your practice?

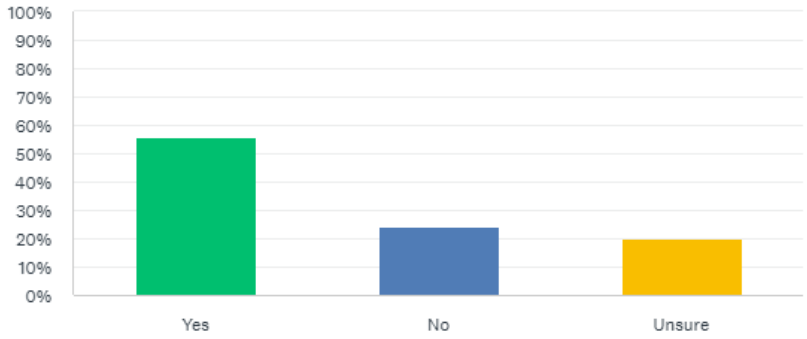


ANSWER CHOICES	RESPONSES	
Very clear	48.89%	22
Somewhat clear	22.22%	10
Not so clear	15.56%	7
Not clear at all	13.33%	6
TOTAL		45

Survey #10: very clear	**Survey #51:** very clear
Survey #12: not so clear	**Survey #53:** not so clear
Survey #13: not clear at all	**Survey #54:** very clear
Survey #16: very clear	**Survey #55:** somewhat clear
Survey #18: very clear	**Survey #56:** very clear
Survey #20: not so clear	**Survey #57:** very clear
***Survey #23:** somewhat clear	***Survey #58:** not so clear
Survey # 24: very clear	**Survey #59:** not so clear
Survey #25: very clear	**Survey #62:** somewhat clear
Survey #27: somewhat clear	**Survey #63:** somewhat clear
***Survey #28:** not clear at all	**Survey #65:** not clear at all
Survey #29: very clear	**Survey #67:** very clear
Survey #31: very clear	**Survey #68:** somewhat clear
Survey #32: very clear	**Survey #72:** somewhat clear
Survey #34: very clear	**Survey #73:** very clear
Survey #35: not clear at all	**Survey #74:** very clear
Survey #37: not so clear	**Survey #75:** very clear
Survey #38: somewhat clear	***Survey #76:** very clear
Survey #39: very clear	**Survey #78:** very clear
Survey#42: not clear at all	**Survey #80:** somewhat clear
Survey #44: somewhat clear	**Survey #82:** very clear
Survey #45: not so clear	**Survey #84:** not clear at all
Survey #48: very clear	

Q18: Are you confident you can apply the standard in your practice?

Public Consultation – Practicing Medicine to Eliminate Anti-Indigenous Racism - **Registrant Survey Feedback**

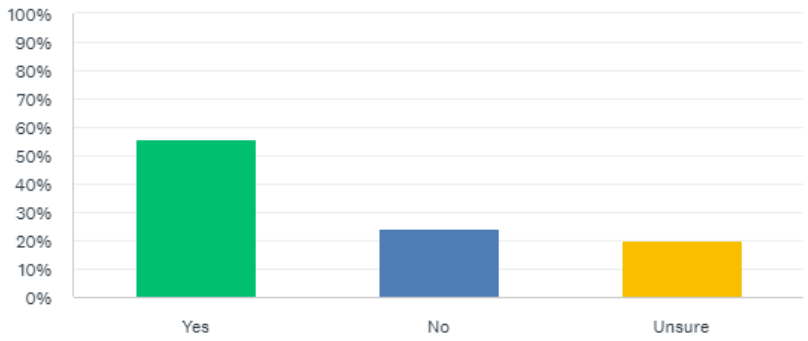


ANSWER CHOICES	RESPONSES	
Yes	55.56%	25
No	24.44%	11
Unsure	20.00%	9
TOTAL		45

Survey #10: Yes	**Survey #51:** Yes
Survey #12: No	**Survey #53:** No
Survey #13: No	**Survey #54:** Yes
Survey #16: Yes	**Survey #55:** Yes
Survey #18: Yes	**Survey #56:** Yes
Survey #20: No	**Survey #57:** Yes
***Survey #23:** Unsure	***Survey #58:** No
Survey # 24: Unsure	**Survey #59:** Unsure
Survey #25: Unsure	**Survey #62:** Yes
Survey #27: No	**Survey #63:** Yes
***Survey #28:** No	**Survey #65:** Unsure
Survey #29: Yes	**Survey #67:** Yes
Survey #31: Yes	**Survey #68:** Yes
Survey #32: Yes	**Survey #72:** No
Survey #34: Unsure	**Survey #73:** Yes
Survey #35: No	**Survey #74:** Yes
Survey #37: Yes	**Survey #75:** Yes
Survey #38: No	***Survey #76:** Yes
Survey #39: Yes	**Survey #78:** Yes
Survey#42: No	**Survey #80:** Yes
Survey #44: Unsure	**Survey #82:** Yes
Survey #45: Unsure	**Survey #84:** Unsure
Survey #48: Yes	

Additional feedback/comments provided to Q18. See below

Public Consultation – Practicing Medicine to Eliminate Anti-Indigenous Racism - **Registrant Survey Feedback**



ANSWER CHOICES	RESPONSES	
Yes	55.56%	25
No	24.44%	11
Unsure	20.00%	9
TOTAL		45

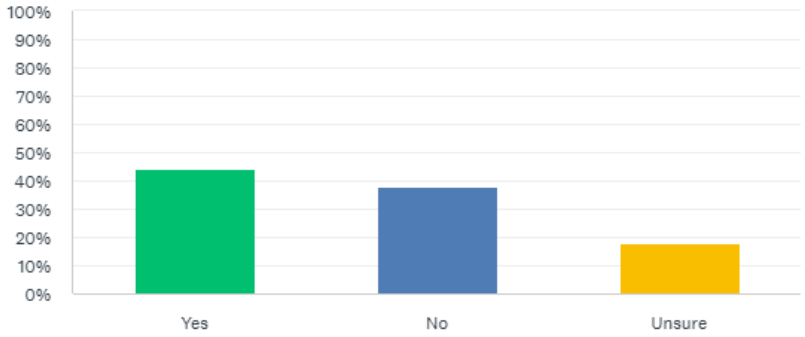
Survey #10: Yes	**Survey #51:** Yes
Survey #12: No	**Survey #53:** No
Survey #13: No	**Survey #54:** Yes
Survey #16: Yes	**Survey #55:** Yes
Survey #18: Yes	**Survey #56:** Yes
Survey #20: No	**Survey #57:** Yes
***Survey #23:** Unsure	***Survey #58:** No
Survey # 24: Unsure	**Survey #59:** Unsure
Survey #25: Unsure	**Survey #62:** Yes
Survey #27: No	**Survey #63:** Yes
***Survey #28:** No	**Survey #65:** Unsure
Survey #29: Yes	**Survey #67:** Yes
Survey #31: Yes	**Survey #68:** Yes
Survey #32: Yes	**Survey #72:** No
Survey #34: Unsure	**Survey #73:** Yes
Survey #35: No	**Survey #74:** Yes
Survey #37: Yes	**Survey #75:** Yes
Survey #38: No	***Survey #76:** Yes
Survey #39: Yes	**Survey #78:** Yes
Survey#42: No	**Survey #80:** Yes
Survey #44: Unsure	**Survey #82:** Yes
Survey #45: Unsure	**Survey #84:** Unsure
Survey #48: Yes	

Additional feedback/comments provided to Q18. See below

Survey #10: I have personally always applied the standard. The College should look into the mirror!
Survey #12: Aside from the establishment of a reporting process, the Standard is too vague for concrete application.
Survey #13: It smacks of McCarthyism.
Survey #25: Many acts of racism are very subtle. Comments in groups and interdisciplinary settings could be quite difficult to address. Specific examples of how to address these instances would be helpful. I hope a similar SOP will be encouraged for allied health groups as well.
Survey #34: Difficulty in caring for some persons from indigenous communities is that it can be difficult to connect with them for follow up appointment as outpatient, either because they change address or they do not attend phone follow up at nursing station. This negatively affects their care. I am struggling to provide continuity of care for these patients.
Survey #37: Most positions have been applying the standard since they have started practice. At least the core values of the standard. If there are any physicians that Demonstrating racist behaviors, then the CPSM should target them for education, but not all physicians.
Survey #42: I will not become a political operative that reports my fellow members for believing in evidence-based medicine and social policy.
Survey #44: Indigenous racism is organizationally embedded, and those who make an effort to point it out are shunned and treated with derision, such that it is uncertain whether this poilcy can have an impact. The whole premise of fee for service practice, for example, potentially fails to address what brings an individual Indigenous person to a physician for care, and yet that continues to be the most prevalent format for remuneration. Individual physicians who try to appropriately serve Indigenous patients are completely unsupported in their own practices. Some of the centers meant for Indigenous population health are overstaffed and underutilized, at times because of their own restrictions to access. These difficult structural realites have to be acknowledged and addressed if inequities in Indigenous health outcomes are to be resolved.
Survey #51: it will be learning curve for all of us
Survey #55: they make sense
Survey #57: I respect my patients rights to be treated with dignity and get all the possible benefits. I worked on reserves before and understand the challenges and nature of First Nations environment.
Survey #59: As a BIPOC person, This seems redundant. Anti racism is a core part of the beliefs of medicine. If someone is actually racist, this will not change their beliefs. Not sure if this will accomplish anything other than superficial signalling.
Survey #72:

It appears to places a nebulous threshold on my responsibility for the perceived experience of racism, implicitly states I have racism in my practice, but does not provide affirmation of the CPSM to fully support registrants if we inherently are racist.
Survey #74: An ethical physician strives to provide care to their patients in context. Sensitive to the 'intangibles' specific to a given patient. There are inherent limits to this. The patient also has a duty to self care and to participate in partnership with the care provider. It needs to be recognized that the provider is also a sovereign individual and not simply a vehicle for providing 'proscribed' care determined by the CPSM (or government etc)

Q19: Are there barriers that may limit your ability to apply the Standard?



ANSWER CHOICES	RESPONSES	
Yes	44.44%	20
No	37.78%	17
Unsure	17.78%	8
TOTAL		45

Survey #10: Yes	**Survey #51:** No
Survey #12: Yes	**Survey #53:** Yes
Survey #13: Yes	**Survey #54:** No
Survey #16: Yes	**Survey #55:** Unsure
Survey #18: Yes	**Survey #56:** No
Survey #20: Yes	**Survey #57:** No
***Survey #23:** Yes	***Survey #58:** Unsure
Survey # 24: Yes	**Survey #59:** Unsure
Survey #25: Yes	**Survey #62:** No
Survey #27: Yes	**Survey #63:** Unsure
***Survey #28:** Yes	**Survey #65:** Unsure
Survey #29: No	**Survey #67:** No
Survey #31: No	**Survey #68:** Yes
Survey #32: No	**Survey #72:** Yes
Survey #34: Yes	**Survey #73:** No
Survey #35: Unsure	**Survey #74:** Yes

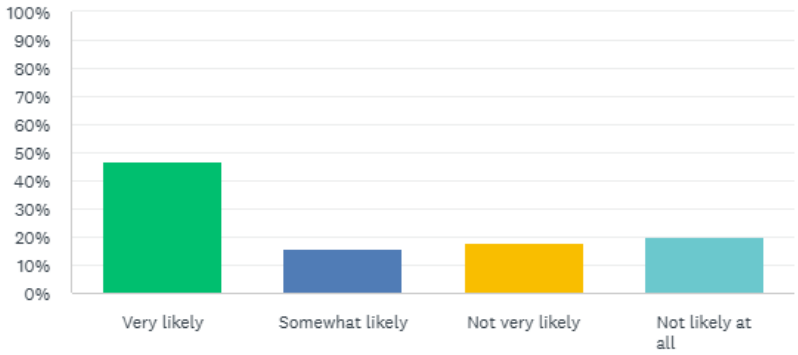
Survey #37: No	**Survey #75:** No
Survey #38: Yes	***Survey #76:** No
Survey #39: No	**Survey #78:** No
Survey#42: Yes	**Survey #80:** No
Survey #44: Yes	**Survey #82:** Unsure
Survey #45: Yes	**Survey #84:** Unsure
Survey #48: No	

Additional feedback/comments provided to Q19. See below

Survey #10: In dealing with powerful institutions!
Survey #12: See comment to Question 13
Survey #13: My colleagues and I are profoundly disturbed by the intellectual overreach of this document. It is totally fine to expect physicians to not be racist. But to demand "anti-racism" at a time when so many self-proclaimed "anti-racists" are anti-Semitic or otherwise racist themselves feels wrong. Are we supposed to turn in our colleagues for perceived "microaggressions"? Will we rise in rank in the party if we report on more people for misinterpreted sleights? As a person of colour myself, I find this document absolutely frightening.
Survey #16: Ongoing systemic structural racism in a colonial health care system will continue to be a significant hurdle to overcome.
Survey #18: There are barriers to calling out racism but there are also barriers to speaking up when libel has occured..that is...when someone is falsely accused of racism. This has happened, and in some instances those accused have received no support from those in power. Practitioners need to know that the health system is supportive in getting to the truth of situations, not in labelling and judging. Perhaps more can be said, or emphasized, about this.
Survey #38: Yes, poorly crafted document
Survey #42: Most of my colleagues are frightened by this document, and many are afraid to speak out believing that you will try to track down and punish anyone who provides feedback. That is the kind of environment you create with documents like this. I suspect the feedback you receive with constructive criticism like this one will probably be limited because of this fear, but these attitudes will absolutely create a barrier to implementing this behaviour modification.
Survey #53: Time and resource limitations as well as lack of indigenous advocate availability in acute/ER settings. I think this is a great idea but there needs to be someone who can also interpret our concerns to the patients to aid communication. Without more indigenous health care workers this will be difficult
Survey #68: novel; adapting to this type of work will require lots of introspection and work to address this in a thoughtful, constant and consistent way
Survey #72:

I feel somewhat disillusioned by it. I agree with large swaths of the sentiments, and personally engage in this issue, but I'm not sure the standard inspires. If anything, I worry it'sa veiled mechanism to be used punitively in very subjective experiences by both registrants and non
Survey #74: Lack of trust by care recipient. This is in part a form of reverse racism
Survey #82: Escalating and having witnessed anti indigenous racism dealt with when done by non Cpsm registrants

Q20: How likely is the standard to empower you to speak up when witnessing anti-Indigenous racism?



ANSWER CHOICES	RESPONSES	
Very likely	46.67%	21
Somewhat likely	15.56%	7
Not very likely	17.78%	8
Not likely at all	20.00%	9
TOTAL		45

Survey #10: very likely	**Survey #51:** very likely
Survey #12: not likely at all	**Survey #53:** not likely at all
Survey #13: not very likely	**Survey #54:** very likely
Survey #16: very likely	**Survey #55:** very likely
Survey #18: not very likely	**Survey #56:** very likely
Survey #20: not very likely	**Survey #57:** somewhat likely
***Survey #23:** somewhat likely	***Survey #58:** not likely at all
Survey # 24: very likely	**Survey #59:** not very likely
Survey #25: very likely	**Survey #62:** somewhat likely
Survey #27: not likely at all	**Survey #63:** somewhat likely
***Survey #28:** not likely at all	**Survey #65:** not very likely
Survey #29: very likely	**Survey #67:** very likely
Survey #31: very likely	**Survey #68:** very likely
Survey #32: very likely	**Survey #72:** not very likely
Survey #34: very likely	**Survey #73:** very likely
Survey #35: not likely at all	**Survey #74:** not very likely

Survey #37: not likely at all	**Survey #75:** very likely
Survey #38: somewhat likely	***Survey #76:** very likely
Survey #39: very likely	**Survey #78:** very likely
Survey#42: not likely at all	**Survey #80:** somewhat likely
Survey #44: very likely	**Survey #82:** somewhat likely
Survey #45: not very likely	**Survey #84:** not likely at all
Survey #48: very likely	

Additional feedback/comments to Q20. See below.

Survey#10: Communication skills of registrants will require improvement!
Survey #12: This Standard is likely to have a chilling effect on frank discussions surrounding racism in healthcare within cohesive professional groups. Individuals within dysfunctional groups may be incentivized to actively weaponize its provisions. Despite assurances that "this program will allow for learning and growth without the fear of discipline", the Standard creates a process by which a new organ of compulsion (the Restorative Practices Program) can be brought to bear by registrants against their colleagues. Even if the procedures of the program are notionally educational, it is broadly understood in such circumstances that the process is the punishment. An overtly disciplinary approach is not preferable. However, if the College nevertheless believes it to be in the public interest that registrants be institutionally confronted regarding behavior perceived as racist, wording that acknowledges the inevitably punitive effects of such confrontation would at least demonstrate that the College is engaging honestly with registrants.
Survey #13: This document should be scrapped, or at least put to a vote.
Survey #16: This standard is long overdue
Survey #18: I have always spoken up. But having this standard is good.
Survey #20: Just because you have drafted a document does not mean it will actually in any way change people's behaviour.
Survey #29: While the standard does help, I would already be very ready to speak up when witnessing any anti-indigenous racism, as well as any other forms of racism or discrimination.
Survey #37: I am not convinced that I have seen a lot of racism in the medical community, Although it is acknowledged that I don't observe many colleagues directly and have only observe students. there is certainly more prejudice against honest, physicians, and that is a much greater problem in our medical system. Our medical system is in complete disarray because criticism has been almost completely muted in the WRHA system. That should be the focus of the next draft standard.
Survey #42: I would be absolutely terrified of saying the wrong thing and creating a political enemy who could seek retribution using this document.
Survey #44:

Regardless of the limitations, it is helpful to have a defined framework to draw upon when dealing with scenarios of oppression and inequality.
Survey #48: I think that before any education is required on this, other than being aware of the contents of the standard, registrants should be able to do a pre-learning evaluation - either some sort of short quiz or write a paragraph and then from that, their learning requirements are decided. This is because there are those of us, like me, who are very much aware of the racism and are reading frequently stories about the past and are in good relationship with our indigenous patients and are having good outcomes as we adjust what we can do for them to what they are able to do. Most of what I see that seems to be racist is more organizational such as poor transportation reliability (pts that don't have cars have to take taxis that are very unreliable and often late or cancel), limited services at the nursing stations due to policies and funding that won't allow willing workers to work or support them so they can, and no recycling or medical clinic laundry provided for the small communities. If you would like specifics, please contact me: [redacted]. Thank you!
Survey #53: Speaking up when witnessing racism isn't limited to indigenous racism. Having a standard of practice doesn't change this.
Survey #55: again be specific with easy protocol Let physician know if they face threats or abusive language…what they should do.
Survey #57: I try to stand by any patient who needs help and provide all assistance to get their rights
Survey #59: This standard isn't needed to do that. If I see racist actions, I will speak up regardless of this draft
Survey #72: I'm empowered by education and community, less so by the standard. I'm less concerned about a college complaint and more about corporate issues re: this
Survey #74: Gross examples of racist attitude blatantly expressed need to be called out. In my 40 years of practice I have witnessed this only once.
Survey #84: As of November 11, 2024, the CPSM web page for "Public Consultations" (https://cpsm.mb.ca/laws-and-policies/CPSM-Consultations) stated in bold green typeface, that "There are no public consultations at this time". Only if a visitor scrolls to the bottom of the page is there a section titled "Open Consultations" where this draft Standard is listed (it is not visible upon loading the page, and one must scroll down to see). A reasonable person, upon reading the first line of the Public Consultations page that "There are no public consultations at this time" would justifiably conclude that there are no "Open Consultations". Whether intentional or not, the CPSM's false statement that "There are no public consultations at this time" has the impact of depriving members of the public from being aware of and commenting on this draft Standard. Failure to solicit public feedback (by falsely stating that there are no public consultations) is a breach of the CPSM's requirement to have public consultations for 30 days. It is requested that CPSM correct the false statement on their website, and extend the public consultation period as requried by policy.

Q21: Do you have recommendations for improving the standard? (optional)

Survey #10: Registrants may be concerned in dealing directly or even indirectly with institutions!
Survey #12: There is already a complaints process. Refrain from creating additional formal programs that can be brought to bear by registrants against their colleagues. Refrain from creating additional obligations that compel registrants to report one another to an institution. Such programs and obligations foster a culture of mistrust and erode collegiality. Instead, work to review existing Standards to ensure they are appropriate to providing culturally competent care. It would be especially helpful to review them with an eye toward ensuring that they account for real geographic and logistical limitations.
Survey #13: Focus on not being racist. Eliminate all discussion of toxic “anti-racism”.
Survey #16: Should clearly state how much Indigenous consultation has gone into this standard
Survey #25: As above, specific examples, (phrases, language) of how to diplomatically address colleagues, allied health, etc. would be helpful in promoting active participation. Accountability is lacking for maintenance of standards.
Survey #32: While I am aware that university of Manitoba is providing antiracism education to our trainees, the standard should also address the Role and responsibility of CPSM regulated full registrants (Physicians) involved in education and training to ensure that these principles are relayed to all physicians in training (residents and students) at least once at beginning of every clinic, ward, operating room, presentation, and ensure that those in training comply with these principles.
Survey #38: See notes to question 8
Survey #39: Summarize some of the additional documentation listed - eg. Metis cancer to encourage members to read it.
Survey #42: Do not adopt it.
Survey # 45: To whom it may concern, I would like to address a few components in regard to the standard on racism. I definitely agree that there is racism within our health care system, but to say that our system is racist is extreme. Yes, our system is built on colonial laws and regulation, but this does not mean that our entire system is racist. We need to acknowledge the racism present in our system, but it is also important to acknowledge the aspects of our system that are not racist as to also look at the positive aspects of our systems. This helps to create hope and avoids perpetuating blame and promoting victimization. In addition, it is not only important to recognize anti-Indigenous racism but all racism. I understand and agree that it is important to learn about the cultural differences as well as values of the patients we treat but we must be careful not to impose the cultural views, values of Indigenous people on non-indigenous people. Unconscious bias can be both negative AND positive. I have seen, and myself experienced, how physicians have used their previous experiences, and biases in favor of their patients. With these biases, physicians may be more cognisant and aware of the determinants of health affecting their patients as well as barriers they may face and hence, use these biases to further investigate their

patients ordering tests that they otherwise may not have ordered and offering treatments knowing that some treatments may not be successful because of barriers and therefore offer different treatments. It is important to recognize that not all biases are negative and that our past experiences can be useful when dealing with similar situations. We must also acknowledge that not all biases are stereotypical but also based on facts; certain populations are at increased risk of diabetes, addictions, alcohol use etc. and if we ignore this due to the fear of being called out as racist, then we may miss opportunities to treat our patients and help our patients. In the standard, it reads "These continue to result in inequitable access to health care." When reading this, one may think that physicians have the "power" to offer access to all but we know that this is a governmental issue. Many physicians try their best to offer medical care to communities that have limited access by going to these communities or facilitating telehealth appointments for our patients. Access to medical care is in large part due to the geographical location of Indigenous communities. Barriers are often based on policies and are out of the control of physicians. We cannot put the responsibility solely on physicians to address barriers to health care. There is also mention of "psychological strain" in regard to the indigenous population in the standard. My question is, what are medical professionals to do when patients are aggressive and violent towards staff accusing them of racism, demanding certain tests and treatments which are inappropriate, using words such as "racism" to get what they want? How will we address patients who have a sense of entitlement due to their past experience, and again who claim racism when medical professionals deny them specific tests/treatments which may not be appropriate for them. This also causes "psychological strain" on the medical staff, causing further burn out, creating anxiety and an unsafe environment at work. I am also concerned about your statement on "inadequate treatment of pain based upon racial profiling". I fear that patients who struggle with addictions could simply accuse the staff of racism in order to get the analgesics of their choice. We already have an opioid crisis in Canada, I fear that now professionals will provide their patients with opioids if this is what they demand out of fear of being called racist. In addition, we know that pain is greatly affected by our experience of pain and our coping mechanisms. In many cases, analgesics are not the sole answer but rather taking the time to listen to our patients and support them can greatly alleviate their physical pain by providing them with coping mechanism and alleviating their emotional and spiritual pain. Your standard mentions a few times the food insecurities, lack of safe housing etc. that our indigenous population faces. How are we going to address these issues of homelessness, addictions etc. within the Indigenous population? Your standard also mentions "refusing to provide care based on patients missed appointments." I definitely agree that we need to be understanding towards patients who miss appointments and treatments as they may face additional barriers financially, with transport etc. This being said, all patients must also be held accountable for their behaviors and consequences of their behaviors. Patient cannot blame our system and the medical professionals when they choose to miss their appointments or choose a certain lifestyle. We should NOT encourage victimization as this only promotes blame, perpetuates racisms, and promotes a negative environment for all. It is also very important not to promote learned helplessness in our patients but to offer them the tools to take control of their own health and participate in their care. The standard also mentions that registrants should be aware of certain barriers such as lack of transportation and interpreters. As much as I agree that these barriers can be detrimental for our patients, these can also be very much out of our control due to lack of resources. It is important to recognize that many of us may try our very best to provide the best care we can to our patients and yet still face barriers; this is not racism. These are challenges that are met due to many factors. To conclude, I agree that something must be done to address the racism within our system but that this must be done carefully to promote a safe environment for

all, patients and health care professionals equally, to promote self-help and hope rather than to continue to perpetuate the ideology of victimization and blame.
Survey #55: there should be free trauma related phycotherapists available for referral after recognization. When every other health related expenses are covered why not psychotherapies.When it comes to pychotherapy or PT related to pain issues ..those are not covered.if PTSD related to past ..EMDR or group therpies by psychotherapist or psych nurses or FP especially trained related to trauma.It should be either a centralised intake for the first nations with previous traumatic experiences or indeginous support group for referral ...to help healing.
Survey #68: narrative or operational examples to guide how the standard can be deployed
Survey #72: I would remove some of the presumptive language. Would also include some affirmation of supporting registrants. This would maybe share the responsibility of a potential complaint from just the registrants.
Survey #78: Perhaps the use of examples
Survey #80: MORE EDUCATION & COUNCELING BUILDING TRUST
Survey #84: See above. At minimum: 1) Remove the duty to report racism and systemic racism. It does not make any sense as I explained above. 2) Remove the requirement to adopt political beliefs about the whether "the system" and "the present" are racist and colonial.

Q22: Do you have any other comments regarding the standard? (optional)

Survey #12: Please be as explicit as possible when outlining transgressions and their punishment. Recognize euphemistic wording as a micro aggression against registrants. Remain mindful of your privileged position as regulators, recognizing the considerable stress that vague regulatory threats impose on registrants. In your own words, "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." This applies to registrants as well as members of the public.
Survey #13: This should go no further. It is a frightening document.
Survey #18: This should go no further. It is a frightening document.
Survey #25: In my opinion it is quite accurate. It should be distributed to all allied health groups as a model to lead education.
Survey #27: Anti-racism and Anti-bias training has been repeatedly studied and found to have no improvements on people's implicit beliefs. In fact it has often been demonstrated to cause people to become more biased through the irony effect. I seriously implore the CPSM to review the actual research on this issue rather than placating political groups in the name of appearing not racist. This has no actual bearing on our patients or co-workers who experience racism. This is nothing more than political pandering and the more we give in to this realm of academic

nonsense, the more autonomy we lose as a profession. I am not remotely interested in having far left academics into the patient and doctor relationship.
Survey #37: No. In the next question, you ask whether I would like to share my contact information. I have spoken about these topics in public, but There are too many troublemakers, wanting to take comments out of context and ruin your career. Therefore, I need to be in complete control of the message if I'm going to reveal my identity.
Survey #42: It was a violation of conflict of interest policy to have the wife of a sitting NDP premier chair the group that authored this document, and the product is overtly political and inappropriate for a CPSM policy.
Survey #51: GREAT START OF FIGHTING RACISM IN ALL APECTS
Survey #55: Health system in the past had not been fair to indeginous population. I like my other collaegues recognise it, though was never a part of any bias toward them. Next part should not more practical guidelines. Special support groups. special psycothrapist senstive and trained to deal this. There should be trained indeginous nurse practioners as well in each reserve. During yearly licence renewal, there can be a self decalartion related to providing services without a bias
Survey #67: Well thought out and presented Very timely
Survey #74: I particularly appreciate stressing personal responsibility as a care provider in challenging our presumptions, embracing humility and a desire for continuing education. Personal commitment is more important than top down edict. The key to patient care is in caring for the patient.
Survey #80: A LONG WAY TO GO GOOD INTENSION / COMITTMENT & CONSITENCY IS THE KEY LOVE IS THE LANGUAGE
Survey #82: -make it more clear who/where to report to, resource with possible reporting pathways/contacts/organizations - more resources/list for ways to access more information/education re colonization, mb history etc
Survey #84: The Restorative Practices Program seems at risk of becoming an unaccountable cudgel for political indoctrination of registrants who hold mainstream political beliefs. Its jurisdiction and roles must be well-defined, transparent, and constrained/limited.

Q23: Would you like to share your contact information? (optional) It may be used to contact you if we need any clarification or if you require a response.

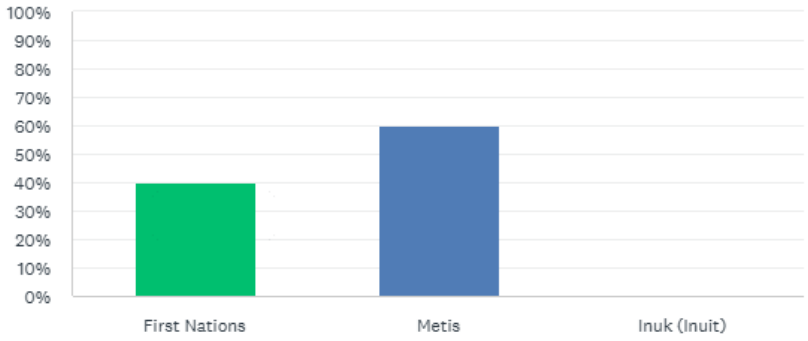
See below those who have added their contact info:

[redacted]		[redacted]		[redacted]		[redacted]	

[redacted]

Q24: Do you identify as any of the following? (optional) Why are we asking this? Data is important for illuminating gaps in medical care. The feedback you shared will help us address anti-Indigenous racism and discrimination. The more we understand about you, the better we can learn and enable change.

There was a total of 5 respondents to this question, 3 being registrants. All three registrants identified as being Metis.



ANSWER CHOICES	RESPONSES	
First Nations	40.00%	2
Metis	60.00%	3
Inuk (Inuit)	0.00%	0
Total Respondents: 5		

Survey #27: Metis
Survey #45: Metis
Survey #65: Metis

Standard of Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism feedback - **written submissions**

I'm an [redacted] working at [redacted]. Both of these facilities see a substantial number of Indigenous patients daily. Also, due to the nature of urgent care, many of the patients of all races leave unsatisfied as they may not get the answers, medications, or testing they were seeking. On top of this they suffer with long waits, an undignified environment lacking in privacy, delayed assistance for eating and toileting, high nurse:patient ratios and staff who at times suffer from compassion fatigue. As a result, [redacted] has higher than average College complaints as reported by CMPA.

I would like to start my feedback by applauding the working group for this effort to reduce the unequal health outcomes faced by Indigenous patients in Manitoba.
However, I do have concerns that it could cause unintended consequences that actually undermine that effort.

In my career I have noticed that there are a number of areas that consistently cause conflict between patients and physicians, regardless of race: refusal to inappropriately prescribe benzodiazepines or opioids, refusal to inappropriately certify disability benefits, reporting unfit drivers to MPI, reporting suspected child abuse/neglect to CFS. Patients are often unhappy with the outcomes of these visits and may misattribute the physician's actions to racism when in fact the physician was fulfilling legal obligations or meeting the standard of care. My concern with this is twofold. First, that this standard will encourage more complaints when care meets standards as patients may attribute all negative experiences to racism. Second, physicians will begin to fear excess complaints from Indigenous patients and compensate by either giving in to inappropriate demands, failing to make legally obligated reports or avoiding practice settings with large Indigenous populations altogether.
The specific wording below in the standard reads to me as if the definition of a racist act or omission is solely within the eye of the beholder and thus it would be very difficult to defend against a complaint in which a patient felt the physician's action was racist, whereas the physician believed they were acting in accordance with standard medical care.

"The intent of a particular act or omission may be bona fide but if the impact on the patient is racist, it is harmful."
I'm not sure how the CPSM would determine if a particular act was a result of unconscious bias or anti-Indigenous racism. Attributing cause and effect is notoriously difficult. For example, in SSRI trials we know that the placebo response rate is high, yet in clinical practice, if a patient improves on an SSRI we generally attribute it to the medication rather than the natural history of the disease. Similarly, we know that Indigenous patients suffer medical errors at higher rates than the general population, however, in any one case it would be very difficult to determine whether an error was caused by anti-Indigenous racism or would have happened regardless of race due to human error within a healthcare system that is drastically under-resourced. If a CTAS 2 Indigenous patient waits 4 hours to be seen they may reasonably suspect it was due to racism, but they may not know that the urgent care had high volumes and short staffing that day.
Again, I think if the Standard leaves the impression that complaints of anti-Indigenous racism are easy to make and hard to defend, it may create the belief amongst physicians that treating Indigenous patients comes with a higher medicolegal risk than treating non-Indigenous patients. It may then be even harder to recruit to already underserviced areas with high Indigenous populations such as downtown Winnipeg or Northern Manitoba.

I don't have an exact answer as to how to improve the document, perhaps more elaboration on how complaints would be addressed could reassure physicians that we will be judged fairly in the context of a system that provides substandard care to most Manitobans (acknowledging that at a population level Indigenous patients get even worse care than the general population).

I'm not sure how this would apply but one of my major concerns regarding Anti-Indigenous Racism is historic (e.g. Manitoba TB treatments/experiments, starvation experiments) and ongoing (e.g. I'm concerned about the standard of care available in nursing stations, charter rights violations in this regard) programatic challenges that Indigenous peoples receiving care from Manitoba have/are facing. I question whether or not the college has a role

in investigation past practices and current practices that may not meet the standard of care and making statements as to whether or not care meets an acceptable standard. I would guess smarter and wiser persons than my self have given this consideration in developing the new standard.
"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." I am a [redacted] If I identify a [redacted] problem that would best benefit from [redacted]; I will recommend that to the referring doctor I don't know about the regional resources available (though I might suspect that access will be a problem) It is a gap in healthcare. [redacted] is not covered but is still the treatment of choice for certain conditions whether a patient can afford it or not. I would still recommend it. If a patient calls to notify us that a plane didn't fly (and that's why they missed) then we wouldn't "hold it against them". If a patient has no showed twice for appts then we do not rebook them. Is there a policy (IN GENERAL) on refusing to provide care based on a history of missed appts?
Thank you for your efforts in the Standard to address anti-Indigenous racism. I have practiced in a non-Indigenous run facility and organization that serves many Indigenous individuals, along with many others from a variety of backgrounds some of which are fairly disadvantaged. The following are my comments on the Standard 1. Physician administrative Indigenous racism and appropriation is also a problem that I do not see specifically addressed in the Standard. For example, in my health region, there was a very inappropriate land acknowledgment for several years. It incorporated the physician leader's racist and colonial ideology and advanced that physician's personal agenda. No one spoke up against it, and it remained unchanged, until after that physician recently left the organization. It is very difficult to challenge someone who is in such a position of power especially in times of duress like we are currently under in health care. 2. Point 36 "Support interdisciplinary team-based practices..." is very difficult in the current conditions of polarized opinions and jurisdictional defensiveness. I tried repeatedly to engage this way with my area's Indigenous-led care and community leaders, on topics like climate change and complex patient care. My overtures have been rebuffed so I am not trying any longer. 3. Indigenous racism is organizationally embedded, and those who make an effort to point it out may find themselves shunned and treated with derision. The whole premise of fee for service practice, for example, potentially fails to address what brings an individual Indigenous person to a physician for care, and yet that continues to be the most prevalent format for remuneration. Individual physicians who try to appropriately serve Indigenous patients are largely unsupported in their own practices. Some of the centers meant for Indigenous population health are heavily staffed and yet underutilized, at times because of their own restrictions to access. These difficult structural realties have to be acknowledged and addressed if inequities in Indigenous health outcomes are to be resolved. 4. There is currently a great deal of understandable anger and defiance among individual Indigenous people and in their organizations. This is not a good place from which to engage. Inappropriate requests (eg from unnecessary antibiotics, to more interventional futile therapies) get labelled as "racist" and can result in disrupted relationships regardless of the amount of compassion and

humility in the discussion. Practitioners can be subject to verbal abuse themselves and the level of trust on both sides is very low at times.

I hope that in time more tolerant and understanding attitudes can prevail on all sides.

[redacted]

I have several comments about the proposed Standard of Practice that I hope will be considered before the Standard if finalized. Before that , I wish to make it clear that I am very aware of the marked shortage of [redacted] resources for both urban and rural/remote Indigenous communities. Additionally, I recognize that the Indigenous peoples of Manitoba consistently experience poorer mental health outcomes and have increased prevalence of mental health disorders compared with other population groups. Most striking to me is that in some demographic Indigenous groups the suicide rate is up to eleven times higher than comparative non-Indigenous groups. I am also aware that this difference started with and is perpetuated by the impacts of colonialism, systemic racism and intergenerational trauma.

Taking the above into account, I have three specific areas I wish the College to consider:

1. Involuntary [redacted] treatment and hospitalization of Indigenous patients
2. The need for physicians to be aware that many allied health staff and Indigenous peoples can find even the most well-intended words to be deeply offensive.
3. There is a significant minority of First Nations, Metis and Inuit peoples that are anti-reconciliation.

1.Involuntary [redacted] Treatment and Hospitalization

As [redacted] we frequently need to invoke the [redacted] Act when a patient, due to a mental disorder, is at risk for harming themselves or others, or at risk for substantial deterioration. This usually results in involuntary hospitalization and/or treatment in a [redacted] facility. Additionally, when a citizen in the community is repeatedly or continuously unable to care for themselves due to a [redacted] disorder they may be placed under an Order of Committeeship and the Public Trustee's office will take charge of their personal and property decisions. The use of the [redacted] Act for these purposes places a great deal of power in the hands of physicians, particularly [redacted], and should only be used when all reasonable attempts have been made to offer care and treatment on a voluntary basis.

For Indigenous peoples, all the above can be re-traumatizing and lead to calls of racism and colonialism against the treating physician. Unfortunately, this can distract from the immediate issue (the treatment of the [redacted] disorder) and impair the working relationship between the patient and the treating team.

Most major hospitals in Manitoba have an Indigenous Services Department, and I believe that in the interest of patient care that these offices have a close working relationship with the [redacted] department of their hospital. Although this is based solely on case reports of [redacted] from around Manitoba, at times the relationship between Indigenous Advocacy departments and [redacted] have been more confrontational than collaborative.

In summary, I suggest the proposed Standard of Practice should include specific guidance regarding involuntary [redacted] treatment of Indigenous peoples, both in hospital and in the community.

2. The need for physicians to be very aware of the language they use.
Remarks can be made that are meant to be helpful or educational, and be taken as derogatory and racist and cause psychological harm to the patient or other health care provider. For example, use of the word "status" is found by some to be derogatory because it indicates that status as a First Nations person is granted by the colonizer under the Indian Act.

[redacted]

[redacted]

[redacted] concern over the sentence from the proposed Standard "...The intent of a particular act or omission may be bona fide but if the impact on the patient is racist, it is harmful. Later in the document the following Question and Answer appears,
"...Q. What are the consequences of a complaint of racism?
..., it is hard to acknowledge that you may not have provided the best care possible, but doing so is the first step to providing that care. It is a learning journey that CPSM acknowledges should have begun Complaints of anfi-Indigenous racism in all forms are taken seriously and will be addressed."
Further on in the answer it states, "...Some matters may be of a very minor nature and can be properly addressed through an informal quick process." In my case, what I consider a minor misunderstanding led to the loss of my position and serious harm to my professional reputation.
To me, the wording of the Standard indicates the CPSM assumes you have breached the Standard of Practice even if you were unaware that the patient felt they had experienced harm by your words or actions. I humbly suggest that the wording in the answer be changed to "...taken seriously and will be investigated" rather than " addressed."
3.Finally, physicians and the CPSM should be aware that not all Indigenous peoples feel that reconciliation is a positive change.
A significant minority believe that reconciliation is "...asking Indigenous peoples to reconcile themselves to white authority over their land and is a fatal compromise."
One of the leading spokepersons of this school of thought is Mohawk scholar and activist Dr.Taiaike Alfred. Here are some selected quotes from his most recent publication, "It's All About the Land".

"...The conclusion I reached is that this aboriginal framework leads to the notion of reconciliation as surrender. It defines us as victims of progress, people who are unable to keep up, need help, who need to brought up to speed and into the mainstream."

"...For Canada, reconciliation means " you native people need to reconcile yourselves to the fact that you lost your land and you are never going to get that land back. Instead you really need to understand what it takes to be a successful, productive consumer citizen in this country we call Canada."

"..."... I (TA) am a big fan of people (settlers) taking responsibility for their privilege and for the things that allow them to have the society that they have and enjoy. And one of those responsibilities concerns the crimes that were committed in their name that allow them to have this prosperity..."

This letter is not to debate about the rightness or wrongness of Taiaiake Alfred's position. My point is that in some situations the College's and the individual physicians' best attempts at reconciliation will be unlikely to succeed when faced with an allegation or complaint of Indigenous racism.

I fully support the need for a full and complete investigation of complaints made to the College, and would add that any investigation must be impartial and that any physician accused of anti-Indigenous racism must have the opportunity to defend themselves. While the proposed Standard of Practice states (In regard to complaints received) "...Some matters may be of a very minor nature and can be properly addressed through an informal quick process." , [redacted].

Thank you for taking the time to read this letter, don't hesitate to contact me if you require further clarification.

1) Page 1 last 3 words "and we apologize" doesn't make sense, remove. Its covered in next paragraph.
2) I like the inclusion of the definitions: I request they somehow make clear the relationship of Indigenous Specific Racism and POWER more clear. Here are some examples from Rain and Chelsey's work

Definitions

Settler colonialism

"is a structure and not an event" (Wolfe, 1999, p. 163).
"settler colonialism's fulcrum is the land; coloniality more broadly is about the stratification of beingness to serve accumulation of material and land" (Patel, 2016, p.7).
Settlers envision belonging to a new place, claim it as home and "this homemaking asserts sovereignty over every aspect of life on the land" (Tuck & Yang, 2012).

Decolonization

"requires non-Indigenous individuals, governments, institutions and organizations to create the space and support for Indigenous Peoples to reclaim all that was taken from them" (Indigenous Corporate Training, 2017).
"is the process of deconstructing colonial ideologies of the superiority and privilege of Western thought and approaches...[and] dismantling structures that perpetuate the status quo and addressing unbalanced power dynamics. For non-Indigenous people, decolonization is the process of examining your beliefs about Indigenous Peoples and culture by learning about yourself in relationship to the communities where you live and the people with whom you interact" (Cull et al., 2019, p.7).
"Decolonization as an ethic and guiding principle for collective struggle is both the ending of colonialism and also the act of becoming something other than colonial". (Barker and Lowman, 2015, p.111).

From Dr Laure hardings Report for BC Coastal health (one does not have to be white to uphold white supremacy or to benefit from it-many examples)
White privilege: Unearned advantages and access that benefit white people, and this privilege is often unrecognized by white people who have not examined race realities or their racial identity.

White saviour: A perspective based on the colonial lies that Indigenous and IBPOC people are damaged, less than human, and in need saving or charity to address inequities with white settlers. Rather than the need for collaboration, following IBPOC leadership and recognizing systemic racism and oppressive systems that perpetuate and normalize racism.

White settler: Descendants of White European colonizers who are dependent on and benefit from colonial policies and the land taken from Indigenous peoples. This identifier applies regardless of when, why or how a person or their family arrived in what is now called Canada.

White supremacy: Belief that white people's ideas, beliefs, and behaviours are superior to people of color and the standard for comparison. This belief creates a political, economic, and cultural system where white people overwhelmingly control power and resources in society, institutions, and in relationships. The danger and risk is exacerbated by the racial power of predominantly white people leading white systems when they are not anti-racist.

Anti-racism: A lifelong practice of acknowledging that racism exists and is harming [Indigenous] people on a daily basis and engaging in active collaborative opposition against it. Anti-racism is an act of responsibility, solidarity, actively identifying, teaching about, disrupting values, beliefs, and practices that create and sustain racism. Radical anti-racism is needed to relinquish the power of white supremacy

Colonialism: Colonizers are groups of people or countries that come to a new place or country to take land and resources from Indigenous peoples and develop a set of laws and public processes that are designed to violate human rights of the Indigenous peoples. This process violently suppresses the governance, legal, social, and cultural structures of Indigenous peoples, and force Indigenous peoples to conform to the structures of the colonial state.

Cultural safety/Indigenous Cultural Safety: A culturally safe environment is physically, socially, emotionally, and spiritually safe. There is recognition of, and respect for, not only the cultural identities of others, without challenge or denial of an individual's identity, or what they need - but also recognizing the reality of discrimination based on race. Indigenous people determine when services are safe. Cultural safety is not static and requires ongoing safety from racism monitoring by the environment, recognizing that Indigenous people are not safe when accessing medical care or any public service. Adding 'Indigenous' as a qualifier maintains the focus on addressing the unique context of the genocidal attempt to eradicate Indigenous peoples from their land and their culture.
Decolonization: The practice of undoing and disrupting Western colonial biases or assumptions that have negatively impacted Indigenous ways of being and caused life altering and life-threatening gaps in health and wellness. Decolonization is about "cultural, psychological, and economic freedom" for Indigenous people with the goal of achieving Indigenous sovereignty — the right and ability of Indigenous people to practice self-determination over their land, cultures, and political and economic systems.

Discrimination: Treating individuals or groups differently based on specific real or perceived characteristics. It can either be conscious or unconscious, verbal, or nonverbal, subtle, and/or passive or overt. Through action or inaction, denying members of a particular social group access to goods, resources, and services. Discrimination

can occur at the individual, organizational or societal level. Discrimination is prohibited in the province of BC based on "race, colour, ancestry, place of origin, religion, family status, marital status, physical disability, mental disability, sex, age, sexual orientation, political belief or conviction of a criminal or summary conviction offence unrelated to their employment". Under B.C.'s Human Rights Code, we are protected from discrimination based on a number of grounds such as gender identity, race and disability.

Indigenous specific racism: The unique nature of stereotyping, bias and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous peoples in Canada that perpetuates power imbalances, systemic discrimination and inequitable outcomes stemming from colonial policies and practices.

3) For unconscious bias make it explicit that if one does not self reflect or monitor oneself or ask for feedback on our blindspots, unconscious bias can lead to interpersonal and engaging in/upholding ISR in systems.
i.e from Dr Hardings BC Coastal health report Glossary:
Implicit bias/unconscious bias: Unsupported unconscious judgments in favor of or against one person, or group as compared to another, in a way that is usually considered unfair. This term is limited when relied upon solely to understand racism. Unquestioned socially normalized stereotypes are not unconscious but accepted and acted upon in systemic racism creating risk and harm that is accepted, taught and embedded into service delivery and system design.

4) Page 4- I hate/am triggered still by the page 4 middle of the page sentence about Indigenous resilience. I think that sentence can be deleted with nothing lost.
5) Standard needs some clear examples of what racism looks like-like in the original Rady College policy, and see tables in the attached study from Toronto. i.e page 4 bullets, not explicit or clear enough yet
6) Page 6 bottom: I don't feel heard yet about the feedback given previously. Indigenous Culture and traditions have NOTHING to do with racism and EVERYTHING to do with White Supremacy Culture. Registrants should be able to define how White Supremacy culture is manifested within our health care systems, within our training and within our practices. The CPSM should be doing an audit of their organization (hire someone, Cheryl Ward or Cheryl and Annette Brown (Equip Health UBC)). Practioners DO NOT have to know our culture or traditions to be anti-racist. They need to know white supremacy culture and how it manifests in health. The bullet list page 6 is weak and move the tip 2 to the bottom of the list please. Knowing history helps, knowing the convoluted path an Indig patient may have to traverse in getting care is essential knowledge. Provincial and federal jusrisdicitons-if you live on reserve vs if you live off reserve and are status the different hoops u jump.

That all I have for now.

Another act of reconciliation CPSM could take on-create a tool kit for physicians (maybe in partnership with Docs MB since it would be a resource for physicians and save on admin burden, smart MD's already have this done so receptionist can do the work i.e Dr M Ellis)- for helping FN, Metis and Inuit patients to get all the resources they are entitled to. Create form letters to go to NIHB so a patient can travel by air and not the HORRIBLE bus (I dare you to the bus from Winnipeg to Thompson with no money and no device and no food and imagine you had just been discharged 18 hours after surgery-this could be another initiative the CPSM spearheads, like MSP out in the cold fundraiser- have select MDs take the bus to Thompson in February as a fundraiser and a walk a mile in our steps, maybe with simulated health issues, schizophrenia headphones, vision impairment, pregnant simulation, mobility impairment etc-use the money raised to support anti-racism in health) or for tool kit a form letter so someone gets an escort (or 2) along with an algorithm for all the reasons someone might qualify. And remind

docs its not their money. IF you would want your relative to travel by air for care then do everything in your power for Joe, homeless, severe SUD and painful spinal abscess to get to travel by air. OK that last paragraph is my unfiltered neurodivergent brain that I am spending less time filtering as I age. 2 great ideas I think that are practical, cheap, promote CPSM to public and government, and could make a meaningful difference.
Thank you for the opportunity to provide comments on the draft Standard of Practice. Our team met to review the document and supporting material which led to extensive discussion regarding the current realities as well as the potential implications should the draft be implemented. We are concerned that this document feels more like "window dressing" and will not result in equitable, non-racist care. The Preamble references the Apology and Statement on Indigenous-Specific Racism. However, an apology is not a true apology when there are no actions taken to reflect the spoken words. Our ongoing experiences reflect the empty promises of the apology. The Hippocratic Oath, an enduring symbol of medical ethics continues to underpin the Canadian Medical Association Code of Ethics and Professionalism. The summary of virtues to be exemplified by the ethical physician leave no room for racism. Clearly physicians and surgeons have not been held accountable to the Code of Ethics, which raises the question why should we have any confidence that the Standard of Practice will be upheld? As an oral based people who believe "relationships are medicine", we would like to invite you to sit with us to have an in-person conversation.

November 11, 2024

Submission regarding the Draft Standard of Practice

Developing a Standard of Practice to address anti-Indigenous racism is an important responsibility and a significant contribution to CPSM's mandate. Congratulations on the work thus far.

As a [redacted], I read the document from a unique perspective and am grateful for the opportunity to share some thoughts.

Mandatory Reporting: There are several references to a requirement to report "systemic racism". I think this needs further clarification. Systemic racism includes complex, deeply entrenched attitudes and practices within society, based on dominant white cultural values. It is incumbent on registrants to understand this concept and begin to examine how routine ways of doing things may disadvantage Indigenous people. This would not necessarily be reportable.

Using more specific language for reporting obligations would be helpful. For example, Page 9 of the Draft Standard says *"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."* In this instance, the term "systemic racism" appears to refer to specific practices or institutional policies in the health care system.

CPSM is legislated to regulate individual members and has not traditionally had specific influence within the health care system. Addressing systemic racism in that context will be challenging. This is not to say that it should not be done. If not CPSM, then who? That said, making meaningful change will require significant resources.

An additional concern about reporting obligations is that the Draft Standard gives an option for registrants to address concerns on their own. This is consistent with a self-regulating professional's obligations, however there is a risk that egregious acts of racism may be dealt with in an ineffective manner and may remain unreported. As reporting to CPSM is a significant responsibility in the draft Standard, further direction about individual responsibility vs CPSM involvement should be included.

How concerns will be addressed: I understand that reporting of racism would be addressed through a new process in the Quality department. I appreciate that the response would depend on the severity of the problem and affirm CPSM's ongoing commitment to the principles of restorative justice where it is appropriate. The documents do not contain details for the process but the approach taken by the Restorative Practices Program should align with the approach taken by the Complaints Committee (CC) or Investigation Committee (IC). These committees have addressed concerns about racism and will continue to receive complaints submitted by patients or their representative that must be processed in a manner consistent with the RHPA. It is common that concerns about racism are submitted as part of a patient's concern about the care they received and an analysis of care forms part of the review and impacts the committee decision.

It is possible that a registrant may report the same (or similar) circumstances to the Restorative Practices Program and it would be problematic for the two processes to arrive at different outcomes.

The ability to address applicable concerns through a restorative approach should be readily available regardless of whether the complaint is addressed through CC/IC or if it goes through the new Restorative Program.

Where the Restorative Practices Program considers that disciplinary action may be necessary, an effective referral to IC would be required. Any referral to IC is subject to the Committee's consideration and the Registrar or the Restorative Practices program cannot presume the outcome or influence the Committee's decision. I suggest that clear guidelines be established for both processes to assist in deliberations.

Other Comments regarding The Standard of Practice:

Preamble: You have indicated *"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."*

I don't understand how CPSM is responsible for the conduct of individuals. I would suggest removing this statement. CPSM's role and apology is well articulated in the paragraph above that begins "In its Apology and statement…".

Concepts that Must be Understood by Registrants: These are helpful and although they are also in the contextual document, it is important to define them in the statement. Consider the following specific suggestions in this section:

- Systemic Racism – Consider this edit "… *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~~ communication.*
- *"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."*
  It is the power imbalance based on the nature of the physician-patient relationship that is relevant – physicians may have less social and economic power than many of their patients.

Three Steps to Practicing Medicine to Eliminate Anti-Indigenous Racism: This heading is not followed by 3 steps. The first step appears to be Acknowledge that Racism Negatively Impacts Health.

The Second Step of understanding and identifying acts of anti-Indigenous Racism could benefit from a few edits:

- *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 registrant's conduct may be well intended, ~~intent of a particular act or omission~~ ~~may be bona fide~~ but if the patient perceives the words or actions as racist ~~impact on the patient is racist~~, it is harmful. It is the harm that must be prevented.*

- The "Know Yourself" section contains some redundant sections that could be eliminated. Sections of the Code of Ethics are contained elsewhere in the documents.
- Under Education, I believe there is an edit required: *"Registrants practicing in Manitoba must ensure an ongoing education, awareness, and understanding of Indigenous Peoples' culture, and history including the importance of trauma informed care.*

The third step is taking action to address racism. See my comments above for concerns about reporting.

I found the instructions in this section to be unclear. Suggested edit: (Page 8): *If ~~you~~ a registrant witnesses or becomes aware of racist behaviour ~~or become aware of systemic racism~~ ~~you~~ they are expected to take action to address it ~~if you can~~ . The action ~~you take~~ required will depend upon the situation, including whether the severity of the concern warrants CPSM involvement. ~~If you are a registrant to whom an act or omission is brought to your attention, you're the~~ A registrant's primary concern is the duty of care ~~is to your~~ to their patient including addressing the harm that has been done ~~when determining appropriate response to address an issue~~. ~~You~~ Where a registrant addresses the concerns with a colleague, they ~~also~~ have a corresponding ethical duty to treat ~~your~~ the colleague with dignity and as a person worthy of respect.*

I suggest eliminating the quotes from the code of ethics that follow related to collegiality. These distract from the main message.

Further Edits Suggested:

Unfortunately, grammatical errors and awkward phrasing were significantly distracting to the content.

The language used in the document sometimes addresses registrants directly ("you") and elsewhere refers to the requirements in the third person ("a registrant"). For example, *"To meet your ethical obligations towards your Indigenous patients requires a Registrant to be aware of…"* I suggest making it consistent with other Standards of Practice, and relevant to the public reader. As such, it may be better to say; "To meet their ethical obligations to their Indigenous Patients, Registrants are required to be aware of…"

The Contextual Document:

I found the contextual document quite helpful. Addressing racism is both straight forward and very complicated. In its simplest terms, it is about treating others how you would want to be treated, which is a concept young children can understand. Understanding how our society is grounded in systemic racism and what constitutes micro-aggressions is much more complicated. Providing resources to registrants for further information is very helpful. The document is quite long and I would encourage some edits to eliminate redundancy with the Standard itself. Again, grammatical errors were distracting.

A few specific suggestions:

- The land acknowledgement should not reference a gathering in this context. *"We acknowledge ~~we are gathered~~ CPSM offices are located on Treaty 1 Territory…"*

- Page 4 – Although the official wording for CPSM references physicians, it is imperative that all registrants understand the importance of antiracism. As such, I suggest *"The medical profession is a self-regulating profession. CPSM's role is to protect the public as consumers of medical care and promote the safe and ethical delivery of quality medical care by ~~physicians~~ our registrants."*
- Page 9 – *Q. Will CPSM determine I am violating the Standard of Practice and conclude I have not met my ethical obligations to my Indigenous patients if I am not aware the way Indigenous-specific racism manifests through attitudes and behaviours such as microaggressions, systemic racism, bias, activation of stereotyping and racial discrimination."*
  This seems like a very long way of asking if CPSM will allow registrants to claim ignorance as an excuse. Consider simplifying, such as "Is it necessary to understand all the factors contributing to anti-indigenous racism for me to meet my ethical obligations to my indigenous patients?"
- Page 10 – Duty to report. See comments above.
- Page 13 - *Q. Are these extra learning requirements just more administrative burdens?*
  I would suggest removing this section. The requirements of the standard may be onerous but I don't think registrants will label them as an administrative burden per se. If you choose to leave this section, I would suggest some edits, to acknowledge that many registrants have thought about these concepts and are already applying them in their practice. "*Registrants will ~~undoubtedly~~ be required to spend time learning or further considering how to ~~E~~eliminate anti-Indigenous racism in the practice of medicine…"*
- Page 13 – Regarding the consequences of a complaint of racism. I fully endorse the statement about the value of a restorative approach where possible and discipline where necessary. See further comments above.

With best wishes in the work ahead,

[redacted]

Standard of Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism feedback - **written submissions**

Dear Dr. Mihalchuk,

RE: Standard of Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism

I was strongly discouraged by multiple colleagues, friends and family members from writing this letter (and to be honest I am quite anxious about this) as I was told it would have negative consequences for me, and no one was going to listen anyway. However, if one sees a pandoras box being opened with potential harms to many, one has a moral obligation to at least raise the points of concern so they can be carefully contemplated and perhaps modified. Not speaking up about potential harms that may occur is the same as allowing the potential harms to occur which is wrong.

I am a healthcare professional that works in the city and in rural Manitoba. Over the last many months (at least) there has been a lot of chatter occurring amongst doctors, nurses, patients and other members of the public that emphasizes what people truly think but are afraid to say out loud. When the Standard of Practice document was brought forward, there was more intensity in the conversations and many different healthcare professionals (doctors, nurses, allied health) discussed unintended consequences they think will come. I don't know if any of them have submitted anything in writing (my guess is not due to fear of punishment/or not wanting to be involved in controversy) but I felt the right thing was to bring some points forward for you to consider.

The main concerns brought up by many were that having these "ideas" out there is going to lead to disengagement by many members of the current healthcare force with many of them (especially rural healthcare workers) leaving healthcare (worsening the current shortage that exists). Unintended consequences also included an increase in complaints to CPSM (worsening CPSM's workload) and worsening care of the public (both indigenous and non-indigenous patients).

Background Information:

- Colonization was harmful. The British and other empires colonized many parts of the world, not just indigenous people in Canada. However, most of the current population (eg. most healthcare providers) have no relationship to the colonizers of the British Empire from centuries ago. Why are we being asked to bear the costs of what was done by someone totally unrelated to us? That does not seem fair.
- It most human relationships, if one has done something wrong to another (note: would argue that current healthcare professionals have not done anything wrong), one usually apologizes once (maybe twice) and then the other party either forgives and both parties work together to resolve issues or the relationship ends. It is not clear why we continue to make regular apologies. This creates a negative/guilty environment which does not lead to collaboration but leads to antagonism when one does not feel that they have done anything wrong.
- Many (most) healthcare professionals work very hard to care for all patients. They (healthcare professionals) pay a lot of money in taxes that subsidizes many of the goods and services that indigenous people enjoy. However, it appears that there is no appreciation for this or proper care for the goods and services provided. Those of us that work rurally will often see vehicles that indigenous people have left on frozen lakes/rivers

because the gas ran out to have these then sink in the spring when the snow melts. Other brand-new equipment provided to indigenous people (from healthcare professional and others tax dollars) is not maintained (changing the oil??) and thus becomes non-functional. Instead of taking some personal responsibility to take care of what is given to them and collaborating to make things better, indigenous people expect us to take care of everything. This does not seem like a normal relationship ... we don't do this with any other culture/people.

- With the widespread publicity of anti- indigenous racism, there are indigenous patient's families now videotaping (on their phones) patient care. The videos include the specific healthcare professionals involved in the patients care and often other patients and healthcare professionals. Videotaping like this goes against hospital policies and privacy laws. This is not allowed by anyone (indigenous or non-indigenous) unless permission is granted, and it involves just the specific patient. When indigenous patients are told by health care team members (and even by administrators) that this is not allowed, the family members accuse the healthcare providers of being racist. They are not being racist ... they are protecting the privacy of other patients and healthcare providers.
- Many would suggest that there actually isn't any racism against indigenous people (at least in present times). We are all (indigenous, non- indigenous, homosexual/heterosexual, healthcare professional/non-healthcare professional) humans. We all have "human challenges". We all expect to be treated in an appropriate way and for there to be give and take in relationships. As healthcare professionals (especially in rural Manitoba but also in urban emergency departments), we often see patients that are aggressive. These patients can be indigenous, Caucasian, Asian, oriental, etc.. They can be very difficult to manage. These patients (any race) are verbally abusive and at times physically abusive causing serious harm (eg. broken bones) to healthcare professionals. As a human, if you were trying to help someone and they were abusive to you or were not participating in a give and take situation to solve a problem (their health problem), the usual human reaction is typically negative. This is not racism, it's a normal human response to negative treatment from another human.
- It is noted that indigenous people have their own traditions and that doctors will be required to spend hours learning about these (also having to pay for the training??). Indigenous people make up ~ 10-20% of the population. Though it is important to understand indigenous culture, what about all the other cultures (Chinese, Hindu, African, Caucasian, etc) that make up the other 80-90% of the population and their methods of healing?? Many patients and healthcare providers (of different cultures) feel they are less important/inferior as their cultures do not have the same level of respect. As is very well known, there are a significant number of healthcare professionals leaving the profession. Asking health professionals to do mandatory training (and paying for it) to learn about a specific culture that is being given more importance than other people's cultures makes people feel bad and will likely encourage people to leave the profession. Patients have also made comments and asked if they would get better care nowadays if they say they are indigenous. This does not seem fair.

Unintended Consequences:

- The above is what many, many healthcare professionals think and "live" – especially in rural Manitoba. They are not happy about it and feel there is unfairness.
- If a doctor knows that there is this Standard and he/she will need to go through a lengthy complaints process or a lengthy restorative education process, this may affect how the physician will behave.
- We have to remember that physicians are humans just like non-physicians and they have the same needs/wants as any other human. They want to do good/productive work, they want to spend time with their families/friends, they want to minimize excess burdens on themselves.
- Hence, physician (especially rurally) may decide to: leave practice, limit the number of indigenous patients he/she sees in practice, not provide "tough love" when dealing with a patient who is drug seeking and just prescribe the drug to avoid a complaint and any educational training time which may lead to bad outcome for the patient; spend extra time trying to do indigenous appropriate care which may provide less time for the doctor to provide culturally appropriate (or even just normal care) to other patients (eg. in a busy emergency department).
- There is a significant concern about the disengagement of healthcare professionals and potentially many more leaving the profession. Though there are healthcare professionals being hired (many international medical graduates), they will likely have even more trouble maintaining the Standard (due to different cultures) leading to complaints and likely the healthcare professionals eventually leaving.
- One would expect that CPSM may get significantly busier dealing with the consequences of the Standard.
- If there are fewer healthcare professionals in the system, it will be harder to care for the patients of Manitoba making it harder to protect the public. There are many non-indigenous members of the public who feel like second rate patients. This is not right.

Possible Solutions:

- Colonization was harmful but the people doing the colonizing and the harms from same are not the current healthcare professionals who are honestly trying to do a good job in a difficult system. Forcing healthcare professionals to learn about one specific culture (that will use their time and money) will cause problems. Having a negative environment (constant apologies, complaints, etc...) will not get healthcare professionals truly engaged.
- There needs to be a positive framework around the process and collaboration (where both parties give and take) to let the past be the past and move forward.
- CPSM may want to put this project on the back burner for now and think about it more. Perhaps there should be a general educational document (not a Standard) emphasizing the importance of treating each and every patient (regardless of race, sexual orientation, religion) etc... with proper respect and care. The educational path training can be on this overall topic. Standard medical therapy would be the expectation. A patient can request culturally specific therapy which the physician can consider and offer if appropriate and if the physician knows how.

Respectfully submitted.

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

November 7, 2024

Via email: cpsmconsultation@cpsm.mb.ca

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

Dear Ainslie:

Re: CPSM, Standard for Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism

The Canadian Medical Protective Association (CMPA) welcomes the opportunity to participate in the public consultation regarding the College of Physicians and Surgeons of Manitoba's draft *Standard for Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism*, as well as the draft *Contextual Information & Resources* document.

As you know, 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.

CMPA is grateful for the College's willingness to engage with us throughout the development of this important *Standard*. We know Indigenous patients experience racism and inequities in our healthcare system and this significantly threatens patient safety and creates negative health outcomes. All healthcare providers have a role in ensuring Indigenous Peoples have access to equitable, culturally safe and appropriate medical care.

We appreciate the College has incorporated some of our feedback in relation to certain elements of the draft *Standard* (*e.g.* educational requirements). However, as previously mentioned, we believe the draft *Standard* could be further improved by:

- Removing the reporting and advocacy obligations; or in the alternative, clarifying these obligations.
- Providing more concrete advice to physicians for overcoming institutional barriers.

Reporting and Advocacy Obligations

We are concerned the draft *Standard* may create an adversarial approach if physicians are mandated to report and advocate against anti-Indigenous racism.

It is our understanding that the College's objective with the *Standard* is to foster education and self-improvement, rather than being punitive. Assuming this is the intent, it would be appropriate for the educational and self-reflection aspects to be mandatory, while leaving the advocacy and reporting expectations as ethical. We appreciate the College has stated that it intends to take a remedial approach for non-compliance with the *Standard*. However, by removing the mandatory reporting and advocacy obligations, physicians are more likely to be able to comply with the *Standard*.

If the College decides to retain the advocacy and reporting requirements, it will be important to clarify these obligations. We expect the *Contextual Information & Resources* document would be the most appropriate mechanism to provide direction on how physicians can fulfil their reporting or advocacy obligations. As currently written, this document provides no such guidance.

For example, direction should be provided regarding how physicians can:

- Properly identify the various forms of racism and know whether they have been able "to remediate" racist behaviour or systemic racism.

- Take "positive action" when advised by Indigenous patients that they are experiencing racism/barriers. Would it be sufficient for the physician to make a report to leadership? Or would they be expected to assist the patient to file a complaint?

Without any clarification, physicians will be unsure when the reporting obligation is triggered or if they are meeting the advocacy expectations.

Overcoming Institutional Barriers

We were pleased to learn that consistent with CMPA's recommendation, the College will be implementing a Restorative Practices Program. We understand that, amongst other things, the Program will respond to calls/inquiries from physicians seeking guidance and provide continuing education. We expect this Program will allow physicians to obtain input on whether their actions or actions of others may be viewed as discriminatory or racist, and what steps can be taken to address discriminatory or racist behaviour, without the fear of discipline.

It was noted in the College's October 23rd webinar, *Truth: the medical profession's first step towards reconciliation*, that the Prescribing Practices Program upon which the Restorative Practices Program is based has resulted in approximately 1% of registrants being referred to discipline. We trust that it will only be when remedial efforts fail, or where the behaviour is egregious, that a physician would be referred to discipline through the Restorative Practice Program.

It would also be helpful if this Program could guide physicians who are regularly challenged by systemic racism on how they can assist Indigenous patients with overcoming complex institutional barriers. We know many physicians struggle with knowing the best approach to advocating on behalf of their Indigenous patients for equitable access to healthcare, which not only includes obvious issues such as access to federal healthcare benefits, but also more indirect problems such as lack of community infrastructure or reliable Internet access. Providing guidance on these difficult issues will assist physicians in feeling safe and supported in their advocacy efforts.

Concluding Remarks

We commend the College for developing this important *Standard*. We hope that with careful drafting and judicious implementation, it will achieve the stated objective of practicing medicine in a manner that prevents anti-Indigenous racism while at the same time ensuring physicians are supported in trying to achieve this objective.

We hope these comments will be helpful in finalizing the draft *Standard* and *Contextual Information & Resources* document. We would be pleased to provide other information or input if that would be useful to the College.

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer

LAC/ml

cc. Dr. B. Singh

Standard of Practice

Practicing Medicine to Eliminate 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.

Anti-Indigenous racism in the practice of medicine is not tolerated. This Standard of Practice will guide and inform Registrants on how to practice medicine in a manner that eliminates 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. Racism directed against Indigenous Peoples in the health care system has been researched, reported on, and acknowledged both regionally and nationally. (see Contextual Information and Resources Practicing Medicine to Eliminate Anti-Indigenous Racism). There is clear evidence of the correlation between anti-Indigenous racism and compromised health.

Anti-Indigenous racism has short and long-term impacts of varying degree. In the most egregious of cases, it has been shown to result in the death of patients. Indigenous-specific racism manifests across the health sector interpersonally through patient/health provider interactions, and organizationally through policies, procedures and the structures that support the provision of health care.

Excerpts from CPSM's Apology and Statement on Indigenous-Specific Racism state:

> "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."

Recognizing that apologies alone 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 eliminate 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 Practice 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 at its core, results in harmful acts or omissions against an identifiable race of people. At a societal level, racism manifests in the systems, policies, and practices that oppress, undervalue, and diminish a worldview, culture or spiritual practice of people based on race. At the individual level, racism is evidenced in the prejudices and discrimination that see people treated differently because of their race. The impacts of these acts or omissions need to be recognized and addressed, whether they were intended or not.

Indigenous-specific racism (anti-Indigenous racism) is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous People. This is a specific form of racism and discrimination that is rooted in Canada's colonial history, policies and practices that

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

perpetuates power imbalances, systemic discrimination and inequitable outcomes. Racism is both violent and harmful.

Systemic racism in health care is often difficult to detect by those who don't experience or haven't been targeted by it. It is hardwired across sectors, organizations, and institutions and is deeply entrenched in institutional policies and practices. It manifests as barriers to accessing health care. In order to identify, remove, prevent, and mitigate racially inequitable outcomes and address power imbalances built in the health care system, registrants must actively work to develop awareness about, and identify changes to the structures that sustain inequities in our practices (see section 3.4 for examples of action to be taken)**.**

Anti-racism is more than a belief that one is "not racist". It is a commitment to and taking a personal responsibility for increasing our knowledge, enhancing self-awareness, and developing the skills necessary to stop racism and discrimination. Being anti-racist means taking action at both the interpersonal and systems-based levels to address the conditions that foster inequitable access to resources and services and that lead to discrimination.

Stereotyping is a specific belief or distorted assumption about a person based solely on their Indigenous identity. Indigenous-specific stereotyping occurs when generalized beliefs about Indigenous people are applied to individuals. The activation of Indigenous-specific stereotyping by healthcare providers often leads to discriminatory treatment (e.g. misdiagnosis, unsubstantiated assumptions about alcohol and substance use, withholding of pain medication, abuse, and curtailed access to necessary medical care) and other behaviours that create a hostile and racist healthcare environment.

Prejudice means to 'prejudge' and is defined by experts as a "disrespectful attitude or negative evaluative response toward groups or to individuals on the basis of their group memberships´ (Jackson, L. 2020). It is a complex concept related to a range of feelings, ideas, responses, and behaviours. These attitudes and reactions can manifest as unpleasant feelings towards Indigenous peoples such as discomfort, anxiety, and lack of respect. Importantly, prejudice can be a predicator of how people treat others. When prejudice is linked to racist stereotyping of Indigenous peoples, it can lead to discrimination and harm.

Racial Discrimination involves "actions, particularly behaviours, policies or practices that lead to inequitable outcomes for groups" (Jackson, L. 2020). In the healthcare context, racial discrimination is the differential treatment provided to/experienced by Indigenous peoples. An important distinction here is that it is not discriminatory to provide care that is *respectful of* cultural norms; rather, discrimination is the action or inaction that contributes to substandard healthcare.

Privilege – It is important for registrants to acknowledge the position of privilege they occupy. In addition to social and economic privilege, there is a power imbalance in their relationship with patients that the impacts the autonomy of decision-making related to

treatment and health. As a counterbalance registrants' behaviour must align with concepts of compassion, integrity and prudence as expressed in the Code of Ethics.

Bias – Whether unconscious or not 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. Biases are our 'gut reaction' to things. These gut reactions develop over time and are shaped by our exposure to media, education, and bias expressed by others. Some biases can cause harm in the form of prejudice, stereotypes, and discrimination. When a negative bias is applied to groups of people, such as Indigenous people, it is called racism. Biases prevent us from seeing fairly and accurately the information or the people in front of us. Addressing biases requires self-reflection, self-monitoring and seeking feedback to become aware of these biases.

THREE STEPS TO PRACTICING MEDICINE TO ELIMINATE ANTI-INDIGENOUS RACISM

1. Understand and acknowledge that racism creates health inequity.
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.

1. UNDERSTAND AND ACKNOWLEDGE THAT RACISM CREATES HEALTH INEQUITY

1.1 The most extreme consequence of anti-Indigenous racism is death. Two public inquiries into the deaths of Brian Sinclair (Manitoba) and Joyce Echaquan (Quebec) (see Contextual Information and Resources Practicing Medicine to Eliminate Anti-Indigenous racism) detailed the profound consequences of anti-Indigenous racism within the health care system.

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. Indigenous patients were described as being less capable, less worthy, drug seekers, alcoholics, non-compliant, bad parents or as individuals who "get stuff for free". The report also highlighted an additional layer of discrimination faced by Indigenous women, girls, Two-Spirit, and gender-diverse people who experience misogynistic stereotyping, child apprehensions, and instances of forced sterilization within healthcare settings.

CPSM recognizes how systemic colonial values, individuals' biases, and racist attitudes have informed the collective role of the medical profession in providing medical care to Indigenous Peoples. The persistence of these values, biases and attitudes continue to result in inequitable access to health care and poor medical outcomes. Compounded over time, they contribute to the suffering and deaths of a disproportionate number of Indigenous patients.

1.2 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, poor concentration and memory problems, irritability, and/or aggression. Because racism is often experienced as violence, it can trigger trauma responses by the person who is targeted. It can also manifest physiologically in the form of high blood pressure, heart disease, gastrointestinal problems, headaches, and back or neck pain.

1.3 Racism can trigger trauma responses by the person who is targeted. To cope or manage racist experiences, individuals may develop adaptive and maladaptive strategies. These responses occur on a spectrum and can include everything from a reluctance to seek help until there is a crisis or leaving the emergency department without full assessment and treatment.

1.4 Systemic racism constrains and, at times prevents access to health care. The systemic barriers experienced by Indigenous peoples are diverse, ranging from racist institutional policies and geographic barriers to access, to resource inequities including poverty, food insecurities, and lack of safe housing. Further deterrents include the psychological strain resulting from racism received from other institutions and/or during medical treatment. CPSM recognizes ongoing examples of Indigenous-specific racism which leads to substandard care including, but not limited to:

- Failing to respect traditional medicine and/or acknowledge Indigenous health care practices as complementary to conventional medicine.
- Accepting or advancing stereotypical perceptions of Indigenous Peoples vis-à-vis alcohol, illicit drug consumption, or socioeconomic status.
- Inadequate treatment of pain based on racial profiling.
- Failing to demonstrate interest, respect, or humility understanding the context of patients' Indigenous teachings, communications, lived experiences, and circumstances.
- Failing to take into account the reality of an Indigenous person's social circumstance and adapt medical treatment plans accordingly. For example, advising care when knowing there may be a lack of access to that care in the patient's community or refusing to provide care based on patients missed appointments which may be beyond the control of the patient.

- Committing outright acts of racism such as uttering derogatory comments about or to Indigenous persons.

2. UNDERSTAND AND IDENTIFY ACTS AND OMISSIONS OF ANTI-INDIGENOUS RACISM IN THE HEALTH CARE SYSTEM AND THE PRACTICE OF MEDICINE

2.1. Racism is viewed from the patient's perspective

To understand and identify an act or omission of anti-Indigenous racism, registrants must recognize the impact on the patient. The registrant's conduct may be well intended, 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 can gain knowledge and understanding of acts and omissions that result in the patient experiencing anti-Indigenous racism.

2.2. Know Yourself / Self Reflection

Humility is identified in the *Code of Ethics* 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.

2.2.1. To work effectively and with humility, registrants must have a sound understanding of the values and beliefs that inform their practice. An important component of self-reflection will be recognizing unconscious biases and the ways it informs practice.

This will be neither comfortable nor easy, but it is necessary for improvement.

Registrants must also recognize and acknowledge the limits of their knowledge and understanding of Indigenous patients and take active steps to educate themselves (e.g. learning about Canada's colonial history and its impact on Indigenous cultures, languages, and traditions).

2.2.2. Registrants must self-reflect on their interactions with Indigenous patients, within the healthcare systems and their role in contributing to the experiences. Considerations include:

- Barriers to patient-centered care and patient participation such as support to navigate unfamiliar systems and access to resources (e.g. transportation, interpreters, escorts, family support etc.).
- Limitations in understanding of the patient's expectations, care needs, and their wishes to pursue traditional Indigenous health care and practices.
- The degree to which Indigenous patients feel safe within the health care facility.

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

2.3. Know Your Patient

Compassion is identified as the first Virtue of an Ethical Physician in the *Code of Ethics*.

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.*

The *Code of Ethics* further specifies registrants are to 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.

2.3.1. To make informed ethical decision-making with their Indigenous patients, registrants are required to be aware of:

- The history of colonization and its relationship to Indigenous-specific racism.
- Indigenous history, especially in the context of land, and the diversity of Indigenous cultures and values across Manitoba.
- Anti-Indigenous stereotyping, prejudice and discrimination and the ways in which they intersect.
- Impacts of historical and race-based trauma
- Micro-aggressions and the ways in which they manifest in health care interactions.
- Unconscious bias and how it influences attitudes towards and the treatment of Indigenous Peoples.
- Barriers to care: systemic racism and its influence over access to care and resources.

2.3.2. As a compassionate physician, registrants must seek to understand the unique circumstances of each patient and to alleviate their suffering. Although registrants will not know the culture and history of every Indigenous patient or community, they are expected to seek out, in a dignified and respectful manner, culturally important factors that may impact the patient's care.

2.3.3. Seeking to understand the unique circumstance of each patient to alleviate their suffering includes asking in a dignified and respectful manner what are the barriers to care they may experience.

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

2.4. Education

A commitment to professional integrity and competence is also identified in the *Code of Ethics*. Specifically, registrants are expected to:

- *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.*

2.4.1 Registrants practicing in Manitoba must commit to and adhere to **ongoing** education, awareness, and understanding of Indigenous Peoples, culture, history including the importance of trauma informed care. **Continuous learning** in this area is considered important and akin to the requirements of 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 Eliminate Anti-Indigenous racism).

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

The *Code of Ethics* requires registrants to:

- *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 commit to justice and society. To that end, registrants are expected to:

- *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.*

3.1 When an Indigenous person receives inadequate 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 must 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.

3.2 Take Action

3.2.1. A registrant who witnesses racist behaviour or is made aware of systemic racism is required to take action to address it. The action taken will depend upon the situation. Some matters can be addressed by the individual and other matters may be beyond their power and control to remediate; however, in all situations positive action needs to be taken.

3.2.2. Various Take Action Options include:

- Disrupting the racist behaviour to stop the harm
- Directly addressing racism and discrimination by:
  - Discussing the matter with your colleague
  - Discussing the matter with your supervisor
  - Seeking assistance from the Restorative Practices Program (see section 3.3.1)
- Discuss the matter with the patient and their support people (see section 3.4)

A registrant's primary concern is the duty of care to the patient. This entails addressing the harm that has been perpetrated. Appropriate responses may be a combination of any or all of the above options. Failure to act when the patient is harmed is not an option.

3.2.3. When a registrant addresses concerns with colleagues, both parties have an ethical duty to treat each other with dignity and as persons worthy of respect. Registrants are governed by the *Code of Ethics* – Physicians and colleagues and are expected to:

> *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.

3.3 Report

3.3.1. If you are unable to remediate an incident of racism or discrimination or feel uncomfortable doing so on your own, refer the matter to the Restorative Practices Program for support and guidance. The Restorative Practices Program is a non-disciplinary program, in the CPSM Quality Department, specializing in restorative practices and emphasizing education and improved medical practice for registrants.

On the continuum of preventing anti-Indigenous racism, the first step is understanding racism and the harm it causes. The second step is recognizing how racism manifests. The third step is taking action. The Restorative Practices Program is responsible for helping registrants do something about racist behaviour or systemic racism that they have witnessed or may have participated in.

The mandate of the Restorative Practices Program is to help registrants improve their delivery of medical care to Indigenous patients. Registrants engage in discussions in a safe environment, without fear of judgment or discipline, about Indigenous-specific racism in the practice of medicine. Through discussion and listening, they explore how to shift their practice to eliminate anti-Indigenous racism. Only when remedial efforts fail, or where the behaviour is egregious, will the registrant be referred to discipline.

3.4 Advocate

Allyship has been described as the actions, behaviours, and practices that leaders take to support, amplify, and advocate with others, most especially with individuals who do not 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:

- Ensuring Indigenous patients are informed of their rights within the health care system (e.g. their right to file a complaint and the process for filing and pursuing a complaint).
- Actively promoting the elimination of anti-Indigenous racism within the workplace.

- Identifying racism/barriers within the health care system and addressing them.
- Assisting Indigenous patients who encounter systemic racism, individual racism, and barriers to health care access receive good medical care.
- Encouraging Indigenous patients to report experiences of racism or barriers to health care and taking timely and positive action when advised of such events.
- Enabling support people (family, friends, or other health care providers) to attend meetings which could facilitate a sense of safety for Indigenous patients.
- Engaging in discussions of Indigenous-specific racism with colleagues and actively pursing solutions to overcome it.
- Taking a leadership role on the healthcare team to promote the elimination of anti-Indigenous racism in the practice of medicine.
- Educating and training learners on the importance of eliminating anti-Indigenous racism from the practice of medicine.

CONTEXTUAL INFORMATION & RESOURCES

For use with the Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism

Developed by:
The College of Physicians and Surgeons and members of the Truth and Reconciliation Advisory Circle.

CONTEXTUAL INFORMATION AND RESOURCES – ELIMINATING ANTI-INDIGENOUS RACISM

CPSM Land Acknowledgment

We acknowledge we are gathered on Treaty 1 Territory and that CPSM regulates the practice of Western medicine on the Treaty Territories of Treaty 1, Treaty 2, Treaty 3, Treaty 4, Treaty 5, and Treaty 5-Adhesion. We recognize these are the ancestral lands of the Anishinaabeg, Anishininewuk, Cree, Oji-Cree, Dakota Oyate, Denesuline and Nehethowuk Nations, and the National Homeland of the Red River Métis.

We acknowledge that northern Manitoba includes lands that were and are the ancestral lands of the Inuit.

CPSM acknowledges and apologizes for its role contributing to the disproportionate health inequities that exist amongst the Indigenous communities in Manitoba. These failures include inadequately addressing Indigenous-specific racism by medical practitioners. We respect and celebrate the resilience and strength Manitoba's Indigenous Peoples have displayed in the face of genocide displacement of their communities

It is a privilege to regulate the practice of medicine on these lands and CPSM pledges to improve. The first step to improvement is continual acknowledgment of our respect for the spirit and intent of Treaties and remaining committed to working in partnership with First Nations, Inuit, and Métis people in the spirit of truth, reconciliation, and collaboration.

About this document

This document was developed to accompany the Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous racism. While it is a helpful resource on its own, it was developed to provide additional information and answer question that may arise from the Standard.

Table of Contents

Introduction

There is a disconnect between the principles of the *Code of Ethics and Professionalism* and the medical care received by many Indigenous Peoples. The purpose of the Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous racism is to examine and arrest that disconnect. The assumption behind the Standard of Practice is that if you are an ethical registrant, you will take good-faith steps to heal this disconnect.

It is important to understand, that this Standard of Practice is about eliminating harm to Indigenous patients; it is not about judging you. As you progress on this learning journey you will have questions. This document is structured to answer frequently asked questions. CPSM is also learning as it goes through this process with you and will continually update this document as we learn.

Q. Who are the Indigenous Peoples of Manitoba?

In Canada, there are three distinct Indigenous groups under Section 35 of the Constitution Act, 1982: **First Nations, Inuit and Métis**. Collectively, they are known as Indigenous Peoples. "Indigenous" or "Indigenous Peoples" is used throughout the Standard of Care to reference First Nations, Inuit, and Métis people of Canada. There is significant diversity between and within Indigenous groups in Manitoba and there are unique cultural, linguistic, and historical factors that shaped their interactions with health systems. There are 63 First Nations in Manitoba, including 6 of the 20 largest bands in Canada. There are 5 linguistic groups including Cree, Ojibway, Dakota, Ojibway-Cree and Dene.

First Nations is a term widely used by Indigenous Peoples. Other terms related to this include '*Status*' and '*Non-Status*". Designation of '*Status'* means that an individual has a specific legal standing under the Indian Act and is registered as a '*Status Indian*.' *Non-Status* commonly refers to people who may identify as Indigenous but are not entitled to be or choose not to be registered under the Indian Act. In Manitoba, there are approximately 165,000 people registered as Status Indians. Of this number, 93,840 people, or 57.1%, live on a reserve.

The Manitoba Métis Federation defines Métis as "a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation." The term "Métis" should only be used where individuals self-identify, and when communities use the term "Métis". It is understood that in Manitoba, the Métis are often referred to as Red River Métis. Of the Aboriginal population in Manitoba, approximately 47,910 (6.5%) are Metis people.

Inuit refers to specific groups of Indigenous people generally living in the far north of Canada, and who are not considered "Indian" under Canadian law. The word Inuit refers to "people" in the Inuktitut language. The singular of Inuit is Inuk. Of the Aboriginal population in Manitoba, approximately 455 (.1%) are Inuit.

Q. Why is this Standard of Practice necessary?

This Standard is long overdue.

CPSM is committed to Reconciliation, and we understand that meaningful change will only come about through acknowledging the past and present harms experienced by Indigenous Peoples, by taking

remedial action to rectify wrongs, and by working to disrupt practices and systems that are racist and discriminatory.

This work is a priority, and each registrant plays a role in fostering a medical community in Manitoba that models and champions positive change. Indigenous-specific racism is an entrenched issue that is clearly having significant impacts on Indigenous Peoples. A Standard specific to the racism and discrimination they have and continue to experience is required.

This Standard of Practice is a set of specified actions, driven by the Code of Ethics and Professionalism, that registrants must utilize to ensure that the medical profession is not perpetuating racism against Indigenous Peoples. Registrants are important leaders in the healthcare system, upholding the Standard and Code of Ethics and Professionalism safeguards professional reputation and public trust.

The medical profession is a self-regulating profession. CPSM's role is to protect the public as consumers of medical care and promote the safe and ethical delivery of quality medical care by physicians. As a profession, we have failed to do so with respect to the Indigenous Peoples of Manitoba. We have apologized for this failure. Now it is time to act to ensure that medicine is practiced to prevent and disrupt Indigenous-specific racism.

In the 2021 Census, 18.1 per cent of the population in Manitoba self-identified as Indigenous. In Winnipeg, 12 per cent of the population is Indigenous. Based on these demographics, it is likely that registrants have treated or continue to treat Indigenous patients. It is well documented in the literature that Indigenous Peoples have not received the care required by the *Code of Ethics and Professionalism.* Indigenous-specific racism is a legacy of Canada's colonial history and is responsible for the long-standing health inequities experienced by Indigenous Peoples.

Q. What has CPSM done about Truth and Reconciliation?

In June 2021, CPSM Council made addressing Indigenous-specific racism in the practice of medicine a strategic organizational priority. From the beginning, we engaged Indigenous physicians, Elders, and other community leaders in forming a Truth and Reconciliation Advisory Circle, which meets regularly and provides advice to reflect on our processes to help us guide the profession.

In January 2023, CPSM met with Chiefs from Anishinaabeg, Anishininewuk, Dakota Oyate, Denesuline, and Nehethowuk First Nations at the Assembly of Manitoba Chiefs to issue a statement and apology "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." In February 2023, we delivered a statement and apology to Inuit leaders from the Manitoba Inuit Association.

CPSM has committed to seven recommended actions recommended by the Truth and Reconciliation Advisory Circle following the delivery of our apologies.

Indigenous-specific racism continues to exist in the medical profession, resulting in great harm. CPSM recognizes that an apology is only the beginning of the important work towards establishing Truth and Reconciliation between the regulator of the medical profession, the medical profession, and Indigenous Peoples in Manitoba.

Q. How will I know if I play a role in any racist behaviour?

The Standard is not just about addressing overt racism; it is also about acknowledging and understanding that everyone has been affected by a range of sociopolitical factors that continue to shape interactions between Indigenous and non-Indigenous people. Indigenous-specific racism functions at multiple levels, including through interpersonal contact as well as through the complex web of organizational and systemic policies, programs, and processes. All Canadians, including medical professionals, have been exposed to, and socialized into the racist stereotyping that targets Indigenous Peoples. This is then taken up through attitudes and behaviours that are harmful and often leads to discriminatory care.

Indigenous-specific racism is expressed in multiple ways and may be intentional or unintentional and attitudes and behaviours may be inside or outside of one's awareness. Interactions are influenced by Indigenous-specific bias, prejudice, stereotyping, microaggressions, and can lead to discrimination and substandard care.

Q. The preamble to the Standard of Practice states that it is an undeniable fact that racism exists in the provision of healthcare to Indigenous Peoples via personal interactions and systemic contexts. It also states that this has been researched, reported, and acknowledged both regionally and nationally. What is the evidence to support this statement?

Several federal and provincial commissions/inquests have identified the need to address anti-Indigenous racism that exists in the healthcare system. This list is not exhaustive.

Manitoba

Brian Sinclair - One of the first such inquests related to the death of Brian Sinclair, an Indigenous person, who died in a Winnipeg hospital awaiting care.

Out of Sight – A summary of the events leading up to Brian Sinclair's death, the inquest that examined it, and the Interim Recommendations of the Brian Sinclair Working Group. It was produced by the Brian Sinclair Working Group September 2017.

> "We recommend that all stakeholders in the healthcare system (including the federal government, the provincial government, Regional Health Authorities, unions, professional organizations, and postsecondary institutions involved in the delivery of professional programs) adopt anti-racist policies and implementation strategies that include committing resources to providing anti-racist training and supporting independent investigations when complaints are filed."

The Southern Chiefs' Organization – *Survey on Experiences of Racism in the Manitoba Health Care System 2021* SCO-Racism-Report.

"It provides examples of experiences that First Nation people have had when facing racism in health care and the range of effects that racism in health care has had on First Nation people."

Quebec

Joyce's Principle - In Quebec, an inquiry into the death of Joyce Echaquan resulted in the creation of Joyce's Principles.

Joyce's Principle aims to guarantee to all Indigenous Peoples the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health.

Joyce's Principle requires recognizing and respecting Indigenous Peoples' traditional and living knowledge in all aspects of health.

Alberta

A recent study published in the Canadian Medical Association Journal in April 2024 found that in Alberta,

emergency department visits by First Nations patients were more likely to end with them leaving without being seen or against medical advice than those by non–First Nations patients because of past mistreatment resulting in mistrust. Leaving without care may delay needed care or interfere with continuity of care, potentially increasing health gaps.

British Columbia

In British Columbia a review was conducted into Indigenous-specific racism in the provincial healthcare system. The report summarizes the findings of an internal review completed based on complaints of racism experienced by Indigenous Peoples in the health care system in the province of British Columbia. There are significant parallels to the Indigenous Peoples in Manitoba.

In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care

Canada

The Truth and Reconciliation Commission of Canada (TRC)

The Truth and Reconciliation Commission identified not just discrimination but acts of cultural genocide perpetrated against Indigenous Peoples in Canada. To move forward on a path towards reconciliation the Commission made 94 Calls to Action, some directly address healthcare.

Truth and Reconciliation: Calls to Action

> #22. We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and elders, where requested by Aboriginal patients.

> #24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Human Rights

As noted in recommendation #24, the Truth and Reconciliation Commission speaks to learning about the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).
The Parliament of Canada enacted the *United Nations Declaration on the Rights of Indigenous Peoples Act* for the stated purpose to "affirm the Declaration as a universal international human rights instrument with application in Canadian law."

United Nations Declaration on the Rights of Indigenous Peoples

Article 24 of UNDRIP states:

> **1.** Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
>
> **2.** Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

In addition to the UNDRIP legislation enacted above, the federal government has taken steps to consult with Indigenous Peoples regarding a Visions for Distinctions-based Indigenous Health Legislation.

Manitoba Human Rights Code

In Manitoba, *The Human Rights Code* is the provincial law that protects individuals and groups from discrimination. There are human rights laws in every province and territory across Canada, as well as a federal human rights law. These laws all promote the principle that all people are entitled to be treated based on our individual merit and should not be subjected to prejudice or stereotypes. These laws are intended to ensure that equality of opportunity and freedom from discrimination, principles found in the Universal Declaration of Human Rights and the Charter of Rights and Freedoms.

Manitoba Human Rights Code

Q. I hear the word "colonization" used in the context of Indigenous-specific racism; what does it mean, and why is something that happened hundreds of years ago relevant today?

There is a saying – "You need to know your past to understand your present."

Colonization is an ideology rooted in beliefs of racial superiority and inferiority. This belief justified colonizers to steal land, exterminate peoples, and impose laws, religions, and actions that are designed to control and oppress Indigenous Peoples.

Several policies and actions were introduced that perpetuated the colonization of Indigenous Peoples. The creation of the Indian Act, and the regulation of identity; the establishment of the Reserve system; the Residential School System, and Indian Hospitals, were key features of colonial actions designed to dominate and oppress Indigenous Peoples. All of these actions contributed to cultural genocide and are intended to extinguish Indigenous peoples as distinct legal, social, cultural, religious, and racial entities in Canada.

The impact of colonization is embedded in today's healthcare system. As we are beginning to become aware of the trauma and violence caused by colonization there is an urgent need to critically assess not only the ongoing impacts of colonization on Indigenous Peoples in the healthcare system, but also the ways that healthcare providers participate in the perpetuation of colonial violence.

Q. What is the racism that Indigenous Peoples have experienced within the healthcare system? How is it different from what non-Indigenous people experience when they need healthcare?

The evidence that Indigenous Peoples experience differential care is well documented and information about this is widely available. It is a fact that Indigenous Peoples experience healthcare that is often substandard, and informed by racist stereotyping, microaggressions, and discrimination. The consequences of this mistreatment are also well documented.

There are numerous examples of the racism Indigenous Peoples have experienced in the healthcare system across Canada. However, several resources identified in this document provide additional context to personal experiences. We would be remiss not to bring your attention:

- Forced sterilizations of Indigenous Women in Saskatchewan (see: The Scars That We Carry: Forced and Coerced Sterilization of Persons in Canada
- Treatment of Joyce Echaquan in Quebec (See: Investigation Report concerning the death of Joyce Echaquan)
- Lack of treatment of Brian Sinclair in Winnipeg (See: Inquest into the Death of Brian Sinclair)
- Nutritional experiments performed on Indigenous children in Residential Schools (See: Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952)
- Use of Indian Hospitals and Sanitoriums

The effects of racist experiences place a heavy burden on individuals, families, and communities. The impacts of racism are far reaching and range from minor negative experiences to death. These experiences may also trigger adaptive and maladaptive behaviours by Indigenous Peoples. In response to differential and racist treatment, Indigenous Peoples may develop a distrust and suspicion of healthcare providers and systems, they may hesitate to seek healthcare when needed or they may only use the health system as a last resort.

.

Q. How does trauma from Indigenous-specific racism harm Indigenous Peoples?

Trauma is a response to highly distressing situations, such as abuse and natural disasters that negatively affect how a person thinks and behaves over the long term. When trauma affects future generations who didn't experience it directly, it is known as intergenerational trauma. This kind of trauma has been documented in children of parents who have survived war, genocide, and other forms of violence and abuse. The consequences of such trauma can be devastating to subsequent generations. For Indigenous Peoples, there are many factors that have uniquely led to intergenerational trauma including the adoption and implementation of the Indian Residential School system where many children endured both physical, religious, cultural and sexual abuse. While most of these harmful policies are no longer practised, multiple generations of Indigenous communities continue to live with the consequences of this colonial violence.

While it is a core competency for healthcare providers to understand the basic socio-political context of all their patients, it is equally important to avoid generalizing and pathologizing communities of peoples based on these experiences. For example, a healthcare provider may understand that the history of Residential Schools has impacted most Indigenous communities in profound and negative ways. However, a colonial trauma-informed healthcare worker will avoid generalizing Indigenous Peoples, while being responsive to the unique ways that individuals respond to their experiences and the persistent racism that continues today.

Q. Will CPSM determine I am violating the Standard of Practice and conclude I have not met my ethical obligations to my Indigenous patients if I am not aware the way Indigenous-specific racism manifests through attitudes and behaviours such as microaggressions, systemic racism, bias, activation of stereotyping and racial discrimination

The requirement is for you to be aware of these concepts when treating Indigenous patients. The greater your critical awareness, the better you can deliver good medical care.

You have taken an oath to provide good medical care to patients. Your oath creates a professional obligation to become culturally aware and reduce instances of anti-Indigenous racism in your practice that perpetuates the harms caused to Indigenous Peoples and communities.

We recognize that obtaining these competencies will not occur instantaneously. See the next FAQ on how to eliminate anti-Indigenous racism in your practice.

Q. What is expected of me to eliminate anti-Indigenous racism in my practice?

Indigenous anti-racism is applicable to all areas of a registrant's practice. You are expected to build and develop (IAR) skills required to provide safe care for all patients and often includes ongoing professional development in several areas. Increasing your knowledge and understanding of Indigenous anti-racism includes an ability to disrupt racism. This practice is a vital skill required to do NO HARM in practicing medicine.

Registrants Expectations:

1. **Self-Reflection (It Starts with Me)** – Registrants must have a sound understanding of themselves and be able to reflect on their own behaviours and actions to recognize the impact you can have on a patient and their relationship with the health care system. Understand your responsibility to disrupt Indigenous specific racism including understanding how your privilege, power, biases, may show up in practicing medicine.

2. **Education and Awareness**– Ongoing professional development is a requirement of all Physicians. Registrants have a duty to ensure they have the necessary Indigenous anti-racism competencies to practice medicine in Manitoba. Continually seek to improve your ability to provide Indigenous anti-racist care for patients.

3. **Duty to Report** – There is an expectation that if you witness racist behaviour and/or become aware of systemic racism that you cannot remediate alone, you have a duty to report it. See the Standard of Practice – Duty to Report Self, Colleagues, and Patients for details. This expectation is extended to registrants, other health care staff, and entrenched practices and systems.

4. **Know Patient** – Registrants are expected to have a good understanding of their patients. This knowledge will assist in better understanding the Indigenous world view and how that impacts an individual's health and relationship to health care. Acknowledge Indigenous patients, listen to understand, show compassion, and offer a culturally safe environment.

5. **Advocate** – Allyship is an important concept in which a Registrant takes responsibility and leadership for actions, behaviours, and practices to support individuals/groups that have been historically marginalized.

Q. What resources does CPSM have to help me eliminate anti-Indigenous racism in my practice?

The University of Manitoba Rady Faculty of Health Sciences has created a ten-module program on Indigenous Cultural Safety developed specifically for health care professionals in Manitoba. At the time of drafting this document, details on enrollment in this program had not been published. When this information is available, this document will be updated.

Wheel of Privilege and Power
This brief but powerful and visual exercise can be used as a beginning point to understand your privilege. Look at the wheel at the link; the closer you are to the centre, the more privilege you have.

As is noted in the answer to the question – "Who are the Indigenous Peoples of Manitoba?" there are distinct groups of Indigenous Peoples. It is important to understand that distinct groups may have distinct health issues. The Manitoba Métis Federation Health & Wellness Department provided these four documents related to health issues facing the Métis:

Riel and Resilient: the impact of climate change on Red River Métis health

The Red River Métis Cancer Journey in Manitoba

"There's a little bit of mistrust": Red River Métis experiences of the H1N1 and Covid-19 pandemics

We're here too: child health information seeking experiences and preferences of Red River Métis families – a qualitative study

The Canadian Medical Association, on September 18, 2024, apologized for harms to Indigenous Peoples. The following are links to various resources associated with the apology:

An apology for harms to Indigenous Peoples | CMA

CMA apology to Indigenous Peoples: Historical and ethical review report - CMA Digital Library - Canadian Medical Association

Wellness and healing resource guide for Indigenous physicians and learners - CMA Digital Library - Canadian Medical Association

Health-related harms to Indigenous Peoples: Selected resources - CMA Digital Library - Canadian Medical Association

Q. Self-reflection (it starts with me) sounds vague, how do I approach it?

Start with the *Code of Ethics and Professionalism,* which states one of the virtues exemplified by the ethical physician is:

> 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.

It is right to acknowledge that you may not know the issues facing Indigenous Peoples seeking medical care. It is right to acknowledge that you may have to look for your unknown biases. You know you want your family, friends, and yourself to be treated with respect when receiving medical care. It is right to acknowledge that persons of a different culture than you may view respectful treatment differently.

Q. What is the purpose and benefit of self-reflection?

Because racism exists in provision of health care to Indigenous patients, we must ask ourselves hard uncomfortable questions about our role and responsibilities. The purpose of asking these hard and uncomfortable questions is not to create negative self-judgment or self-criticism, but to increase self-awareness so we can make better decisions and make improvements.

The toughest question to answer is – "what racist acts or omissions have I done that caused my Indigenous patients harm?" None of us want to admit that we have harmed Indigenous patients but by acknowledging this has happened allows us to make change.

Because we may not know about Indigenous cultural values and history, or impacts of trauma, micro aggressions, systemic racism and unconscious biases we may be unaware that our acts or omissions are causing harm. We need to recognize that we have deficiencies in our knowledge, and we must learn about these topics so that we can better assess our actions and areas for improvement.

The *Code of Ethics* provide an excellent measuring stick to help us assess where we are and where we want to be.

Q. What are the key concepts I need to understand and where can I get further information on them?

Indigenous-specific racism - 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, practices, systems, and structure. Racism is a form of harm.

Eliminating anti-Indigenous racism – CPSM's Standard of Practice was designed to inform and guide registrants on the harms that Indigenous patients experience from racism and how to practice medicine in a manner that eliminates anti-Indigenous racism. Three steps explicit in the Standard of Practice are:

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.

Self-awareness - The acknowledgment of difference. It is the first step in understanding cultural differences and involves observing those differences. Cultural awareness focuses on the 'other' and the 'other culture.' Cultural awareness does not consider political or socio-economic influences on cultural difference, nor does it require an individual to reflect on his/her own cultural perspectives. *Source: Canadian Indigenous Nurses Association (2013). "Cultural Safety in First Nations, Inuit and Métis Public Health"*

Registrants must assess and respect the values, attitudes and beliefs of persons from other cultures and respond appropriately in planning, implementing, and evaluating a plan of care that incorporates health-related beliefs and cultural values, knowledge of disease incidence and prevalence, and treatment efficacy. *Source: Canadian Nurses Association (2018). "Promoting Cultural Competence in Nursing*

Patient Safety – - an outcome based on respectful engagement with patients that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.

Microaggressions - are the everyday slights, insults, putdowns, invalidations, and offensive behaviours that people experience in daily interactions with generally well-intentioned individuals who may be unaware that they have engaged in demeaning ways.

Restorative Justice - refers to an approach to justice that seeks to repair harm by providing an opportunity for those harmed and those who take responsibility for the harm to communicate about and address their needs in the aftermath of wrongdoing.

Traditional Indigenous Medical Practices - can include ceremonies, plant-based medicines, Elders' prayers and counselling and other techniques to promote an individual's physical, mental, emotional, and spiritual health and well-being.

Q. Are these extra learning requirements just more administrative burdens?

Registrants will undoubtedly be required to spend time learning how to Eliminate anti-Indigenous racism in the practice of medicine. Learning how to apply the Code of Ethics and Professionals in the context of medicine is not an administrative burden; learning how to provide improved medical care is a professional responsibility.

First, start by acknowledging there is a problem in the way healthcare is provided to Indigenous Peoples in this province.

Second, remember your ethical duty to ensure patients receive good medical care, and self-evaluate how you can improve the medical care you provide.

Third, it is hard to acknowledge that you may not have provided the best care possible, but doing so is the first step to providing that care. It is a learning journey that CPSM acknowledges should have begun a long time ago.

Q. What are the consequences of a complaint of racism?

Complaints of anti-Indigenous racism in all forms are taken seriously and will be addressed. The goal of this Standard of Practice is to ensure Indigenous patients receive good medical care and are not harmed by racism. The nature and extent of possible acts or omissions of racism can vary greatly and are best viewed as being on a continuum. How complaints and concerns are addressed will depend upon where the matter is on the continuum.

CPSM believes restorative approach principles will be important to addressing complaints and concerns; however, restorative approach principles may not be appropriate for matters that are at the ends of the continuum. Some matters may be of a very minor nature and can be properly addressed through an informal quick process. Other matters may be of such a serious nature that the appropriate resolution is a suspension or loss of the registrant's ability to practice medicine. These matters would require a more formalized discipline process.

Providing a forum for registrants to learn and harmed patients to heal is what CPSM is attempting to achieve. However, when a registrant has acted in contravention of the Standard of Practice positive change is mandatory, continual contravention is not acceptable.

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Mandatory Training – Truth and Reconciliation**

BACKGROUND:

One of the 7 recommendations of the TRC Advisory Circle approved by Council on September 29, 2022, was "Mandatory Indigenous-Specific Anti-Racism Training for CPSM Registrants and Staff." As noted in **Agenda Item 7**. education is imperative to eliminating anti-Indigenous racism in the practice of medicine. Registrants cannot eliminate anti-Indigenous racism from their practice if the do not know what it is, know how to identify it, and know what steps to take to eliminate it. Knowledge comes from education, and this education is mandatory for all registrants. (CPSM staff have taken this training and new staff are required to take it upon hire.)

Council must decide:

- What is acceptable mandatory education for registrants?
- When must the mandatory education be completed?
- What are the requirements for subsequent mandatory education?
- Are there any exceptions to taking the mandatory education?

What is acceptable mandatory education?

CPSM has identified the following education programs (information on each is attached as *Appendix A*) that provide an important baseline knowledge for registrants:

- Giga Mino Ganawenimaag Anishinaabeg ("We will take good care of the people"), University of Manitoba, Ongonisszwin-Indigenous Institute of Health and Healing.
- The Path: Your Journey through Indigenous Canada (CMA version), NVision Insight Group.
- San'yas Indigenous Cultural Safety Online Training, San'yas Anti-Racism Indigenous Cultural Safety Training Program
- Indigenous Health Program, Rady Faculty of Health Sciences – Max Rady College of Medicine.

CPSM recommends that satisfying mandatory education requirements for indigenous specific anti-racism training be available from several different service providers due to potential issues of accessibility. As there may be other acceptable programs that CPSM is not currently aware of, or which may be developed in the future CPSM recognizes that it also needs to have discretion to accept equivalent training programs. CPSM will also consider training

equivalencies. A registrant can apply to the Restorative Practices Program for accreditation of other acceptable training that they have taken.

When must the mandatory education be completed?

CPSM recommends that all registrants complete the mandatory education by October 31, 2027. New registrants after October 31, 2025, will have 2 years to complete the mandatory education.

What are the requirements for subsequent education?

CPSM recommends that all registrants complete a subsequent education course within 5 years of the completion of the first education course.

Are there any exceptions to taking the mandatory education?

CPSM recommends that no registrants be exempt from mandatory education. That said, registrants who have previously taken one of the above-mentioned education courses prior to the coming into force of this policy will not be required to take mandatory education until 5 years after the date they completed the previous education.

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves:

1) All registrants, subject to clause 4, be required to complete one of the 4 the education programs identified in the background section, or an equivalency approved by CPSM (hereafter referred to as "Education"), by October 31, 2027.

2) All new registrants after October 31, 2025, must complete the Education within two years of becoming a registered member.

3) All registrants must take additional Education every 5 years thereafter following completion of the first round of Education.

4) If a registrant has prior to the date of this motion taken one of the identified Education, they will be deemed to have satisfied the requirement of clause 1 and will be required to take additional Education specified in clause 3 within 5 years of the completion of that initial Education.

Truth and Reconciliation Education Programs

- **Giga Mino Ganawenimaag Anishinaabeg ("We will take good care of the people"), University of Manitoba, Ongonisszwin-Indigenous Institute of Health and Healing:**

  https://umanitoba.ca/ongomiizwin/education/we-will-take-good-care-of-the-people

- **The Path: Your Journey through Indigenous Canada (CMA version), NVision Insight Group:**

The Path
Your Journey through Indigenous Canada

Online Learning Option

This course, ***The Path: Your Journey through Indigenous Canada***, partially meets the Truth and Reconciliation Commission (TRC) Calls to Action for Canadians to receive 'cultural competency training'[1] by teaching about "the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal– Crown relations."

NVision Insight Group is a majority Indigenous-owned consulting company with First Nations, Inuit, Métis and non-Indigenous shareholders and staff. NVision is an authorized vendor and provider of cultural awareness training for the Canadian Council for Aboriginal Business (CCAB).

Contents

[1] Various Calls to Action call upon different sectors to *"receive appropriate cultural competency training, which includes the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal– Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism."* In order to fully meet the TRC's Calls to Action for cultural competency, NVision has a follow up course called ***The Path: Building Indigenous Intercultural Competency***. Please see the information sheet on that course for more details.

About *The Path* -

NVision has been offering Indigenous cultural awareness workshops since 2010 and launched ***The Path: Your Journey Through Indigenous Canada***, our online course in 2018. The course was updated and modified in 2020, and revamped in 2023. The course is available as an online course (7 hours at your own pace), as an in-person workshop (1 day) and as a virtual classroom course (6 hours spread out over four sessions). All three course delivery options cover the same material.

The course is also available in French. It is called ***Le Parcours : Votre voyage au sein du Canada autochtone.*** Veuillez contacter thepath@nvisiongroup.ca pour obtenir des fiches d'information en français.

The Path has been developed with input from adult learning experts and curriculum developers. NVision has had First Nations, Inuit and Métis advisors and reviewers in the preparation of this course. Please note that the course has also been vetted by an Indigenous lawyer for accuracy related to legal references.

The Path presents pre-contact societies and cultures and the defining moments that have helped to shape the history of Indigenous peoples in this country we now call Canada, particularly their relationships with European settlers, the British Crown, and the Dominion of Canada. The course covers topics such as residential schools, forced Inuit relocations, 60s Scoop, disease epidemics, the treatment of Indigenous peoples in Canada's health and legal systems, and the consequences and impacts of colonization. The course demystifies some of the legal issues regarding the *Indian Act,* historical and modern treaties, and Aboriginal law. Finally, this course provides some context to better understand the importance of cultural traditions and values of First Nations, Inuit and Métis, and ways to strengthen relationships with Indigenous peoples.

The Path might qualify as accredited learning. While NVision is not an accrediting organization or institution, clients can check their own professional development requirements to determine if ***The Path*** can be recognized as accredited professional development hours. Clients can pursue this option in the clients' sector. For example, ***The Path*** is an eligible education activity for all provincial law societies and is accepted as Continuing Professional Development (CPD) hours for lawyers in Canada.

Your cultural awareness journey supports Indigenous charities! For every online ***Path*** seat purchased, NVision will donate 5% to a registered Indigenous-led charity of your choice (or contact NVision for a list of charities to choose from).

Online Course Overview

On NVision's LMS

The course is hosted on NVision's online Learning Management System (LMS) www.nvisionthepath.ca On this LMS, there are videos, interactive exercises, a workbook, quizzes, post-course survey questions and a certificate of completion.

Participants register for the course on the LMS and are provided with an enrolment key (password).

The course consists of six modules, each module is approximately 40 to 50 minutes in length and includes several related lessons (see details below). At the end of each module, there is a knowledge assessment with 12 to 20 questions (a blend of True or False and Multiple-Choice questions).

There are no limits to the number of individuals who can take ***The Path*** online. Cost is based on a per seat basis, according to the sliding scale of costs.

See information below, if you are a membership-based organization, and want to administer the course registration, and direct learners to NVision's LMS to take the course.

On a Client's LMS

Alternatively, ***The Path*** is available to upload to a client's LMS. NVision will provide a SCORM 1.2 version package of the English and French courses and all accompanying materials (quizzes, resource documents, survey questions, certificate of completion). NVision requires a three-year licence agreement to allow the client to upload the course to their LMS. Clients can choose upfront, full payment or annual installment payments.

Please note, if a client requests the SCORM package, NVision assumes the client will make ***The Path*** mandatory for all staff. NVision will charge (on a per seat basis, based on our sliding scale), for the full complement of staff members currently employed with the client's organization.

Offering *The Path* to your Members or Partners

If you are a membership-based organization or work with multiple partners, clients, or members, and you want to oversee the registration and payments for access to ***The Path***, this is an option. NVision currently has existing arrangements with the Canadian Bar Association, Royal Architectural Institute of Canada, Canada Mortgage and Housing Corporation, and the Canadian Live Music Association. The process works like this:

a. The client estimates the number of members who *might* take the course (best estimate) over a one-year period. This will determine the per seat discount that NVision will offer.

b. The client selects the number of technical reports required over a one-year period (usually monthly or quarterly)

c. NVision will invoice for set up and technical support for one year but will *not* invoice for any seat purchases up front.

d. NVision will create a new iteration of ***The Path*** on NVision's LMS with the client's logo and a specific enrolment key.

e. The client will create a portal on their web site (or designate one person's email address to process all registrations). See hyperlinks above for examples.

f. The client will promote and market ***The Path*** to their members, sending them to their web site or designated email address.

g. The client will accept all payments and track all registrants.

h. Upon receipt of payment from a member, the client will provide the member with instructions with the link and the enrolment key to take ***The Path*** on NVision's LMS.

i. At the end of every reporting period (monthly or quarterly), NVision provides a technical report with the names, email addresses and number of registrations from that reporting period. The client reviews and compares NVision's list with their own list to ensure they match. The client provides NVision with a Purchase Order outlining the number of registrations that month/quarter, and the amount collected.

j. NVision then submits an invoice for the amount indicated.

Contact NVision for more details at thepath@nvisiongroup.ca

Customizing *The Path*

Clients have the option of developing custom elements of ***The Path*** online. The following are a few examples of the types of customizations developed by previous clients. You can do any or all of the options listed below. NVision is flexible and open to other suggestions and ideas in order to ensure the online course is relevant, effective, and appropriate for your employees.

1. **Introductory Video.** You can record a President/CEO/Lead Executive giving a short video introduction, welcoming participants to the course, outlining the value of Indigenous cultural awareness training, providing a brief outline, and explaining why it is important and relevant. This introductory video will be added and integrated

prior to Module 1, and all participants are required to watch it. NVision is available to assist with drafting text for this introduction.

2. **Inserting material into an existing lesson.** You can work with NVision to create a 3 to 5-minute segment to be integrated into an existing lesson. For example, some clients want to mention their company/organization's reconciliation strategy or their engagement principles or their policies on Indigenous inclusion. This could be inserted into Module 5, Lesson 2, and will be a seamless addition to the existing lesson.
3. **Creating a new lesson.** You may want to produce a new lesson specific to your company, industry, or region. For example, if you are a company that is based in Saskatchewan, you may want to create a new lesson in Module 2 about pre-European contact First Nations history and stories in what is now Saskatchewan. Or if you are a mining company in in Nunavut, you may want to create a new lesson in Module 5 in order to discuss specific Inuit cultural values and realities of working in modern treaty territories, along with Inuit-specific examples in relationship building. The 'rule of thumb' when creating new learning content is $1,200/minute. In other words, if you want to create 5 minutes of new content, it will cost approximately $6,000.
4. **Kitchen Table discussion.** As a value added, all learners who have completed the course can participate in a Zoom or Teams Q and A with NVision; Jennifer David (English) or Lisa Abel (French). This session, called a Kitchen Table discussion, is a safe space for learners to ask questions, seek clarification and reflect on what they've learned. There is no presentation, but the facilitators will ask a few guiding questions. One Kitchen Table discussion is available to each client at no cost. Any additional sessions are charged at the facilitator's hourly rate.
5. **In-person workshop add-on.** You may want to have all employees take the course online then augment the learning with an in-person workshop for a select group of employees who may be front-facing with Indigenous clients, or who engage closely and regularly with Indigenous peoples. The length, format and topics for this half-day workshop would be developed with the client. For example, NVision could generate scenarios or case studies for group discussion, or facilitate a virtual guest speaker presentation on Path topics.

Schedule and Time Commitment

The course takes approximately 7 hours to complete. Participants move through the modules at their own pace. If the course is taken on NVision's Learning Management

System (LMS), participants generally have 365 days from the day the course opens, to complete the course (unless the client chooses a shorter or longer timeframe), after which time they are automatically unenrolled.

If the course is sold to a client that makes it available on the client's own LMS, the client determines the time limit expectations for their employees, though the course will be accessible for three years, as per the licence agreement.

A certificate is provided upon successful completion.

Advantages to Online Learning

- Is available on-demand and can be done at participants' own pace
- Identifies and achieves company corporate social responsibility goals
- Saves time and money on travel
- Can be purchased and offered on a client's LMS or through NVision's LMS
- Appropriate for all adults (some graphic and disturbing video means it is not appropriate for children)
- Internet access is required but high bandwidth is not (all videos are low resolution)

Cost

The course is offered at $190 per person, up to a group of nine. If there are 10 or more participants, NVision has a sliding scale of costs which reduces this per-person cost. Please contact NVision for further details.

This per-person costs include access to our online Learning Management System.

Additional costs, depending on your organization's needs or requirements include the following:

- If the course is on NVision's Learning Management System (LMS), there will be tracking and reporting costs. One monthly report contains cumulative completion and enrolment information; the second report contains survey data and responses to standard survey questions. The cost is one hour (@$195/hour) per month for the duration of the contract (usually 6 or 12 months, depending on the number of participants).
- Once participants complete the course, there is a short online satisfaction survey. If the course is on NVision's LMS, a client can develop its own pre-course and/or post-course survey. This will cost approximately $1,000 (assuming 10 questions).

- If your company/organization has its own online Learning Management System (LMS) and wants to administer, offer and manage ***The Path*** itself, it costs $500 to convert the English and French course to a SCORM-compliant version.

Why Choose *The Path™*?

- It's designed by NVision, a majority-Indigenous company (including First Nations, Inuit, Métis and non-Indigenous ownership and staff)
- All course content has been vetted by First Nations, Inuit and Métis advisors and reviewers
- It meets various TRC Calls to Action regarding cultural competency training which includes learning about "the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal– Crown relations."
- This course meets all provincial accessibility standards for audio and visually impaired learners. All course slides are narrated, all videos are close captioned, and a master script is available.
- It's the only course of its kind to focus in equal depth on First Nations, Inuit, and Métis
- It was created by our team of educators and instructional designers using Articulate Storyline, and combines solid adult learning principles with innovative approaches to web-based content delivery
- The course can be customized with industry/sector or regional-specific elements to better meet the needs of your organization
- The course is available in French/le cours est disponible en français

Module Descriptions

Module 1: Name Calling

Lesson 1: Indians, Inuit, and Métis

Your journey begins with an exploration of what the Canadian Constitution calls the 'Aboriginal people of Canada,' and a review of why and how First Nations, Inuit, and Métis are distinct. We will delve into some of the common words used to describe Indigenous people, past and present, and help you understand how and why to use (or not use!) certain terms.

Lesson 2: Stereotypes and Misconceptions

Words can wound; and many words, terms, and descriptions of Indigenous peoples reflect and sustain racist, stereotypical narratives. We will debunk some of the most egregious of these stereotypes and misconceptions and encourage you to counter them.

Module 2: Land, People and Stories

Lesson 1: Land Acknowledgements

To really understand the Indigenous peoples in Canada; it is important to acknowledge their past, present, and ongoing relationship to their land. It has become a common convention to begin events with land acknowledgements, to include them on web sites, and even to add them to email signatures. But what exactly IS a land acknowledgement? Why do people do land acknowledgements? When and how should they be used? In this lesson you will learn about the meaning and importance of land acknowledgements.

Lesson 2: Origin Stories

Author Thomas King said, "The Truth about Stories is, That's All We Are." Stories are integral to Indigenous culture; they shape our societies. You will learn about the importance of storytelling, with examples from across the land now called Canada. You will understand why First Nations say they have been here 'since time immemorial,' and explore the origin of laws, societies and cultures that have existed for thousands of years. You will also learn how the Métis Nation emerged with the growth of the fur trade in the 17th century.

Lesson 3: Inuit Across the North

For many Canadians 'Indigenous' cultural awareness refers to 'First Nations' and sometimes 'Métis', with little or no awareness of Inuit. This Lesson will introduce you to pre-contact Inuit culture, review the major milestones that have impacted Inuit since the arrival of Europeans, and describe how each unique Inuit region came to be shaped and defined through the land claim process.

Module 3: Canada's Colonial History

Lesson 1: From the Arrival of Strangers to a Royal Proclamation

The first Europeans to arrive on these shores were looking for a shortcut to Asia. They did not find one; but once they saw the vast natural wealth (first fish, then furs, then minerals, timber, and other resources), they were keen to exploit this "new" world, colonize and Christianize what the "savages", and settle and populate the land with Europeans who shared their racist assumptions of superiority and supremacy. First Nations and Métis were integral to the fur trade, and early agreements were based on Peace and Friendship; and when the British defeat of France and became the leading colonial power, the Crown

proclaimed that First Nations and their land must be respected. It seemed a promising beginning; but as you will learn, those original colonial assumptions have had enduring and disastrous impacts on Indigenous peoples.

Lesson 2: Denial of Rights from 1763 to the Dominion of Canada

While the Royal Proclamation acknowledged that there was such a thing as 'Indian land;' the relationship between the British Crown, European settlers and First Nations and Métis peoples began to unravel in the 19th century. Partnerships based on mutual benefits, peace, friendship, and respect collapsed under the weight of coercion, broken treaty promises, displacement, forced assimilation and genocide, all of which were enshrined when Canada became a Dominion in 1867.

Lesson 3 Colonization since Confederation—Numbered Treaties

The new Dominion of Canada was keen to build a railroad across the country and 'open the West' for agriculture, resource development and settlement. They first needed to purchase Rupert's Land from the Hudson's Bay Company, then enter into treaties with First Nations. Time and time again, the treaty negotiations were marred by dishonesty and bad faith on the part of the Crown, with benefits flowing primarily to Canada to the detriment of First Nations.

Lesson 4 Colonization since Confederation—Other Defining Moments (20 minutes)

When the Dominion of Canada was created by the *British North America Act* in 1867, the new government introduced laws, policies and processes that devastated Indigenous peoples. These included the oppression embedded in the *Indian Act*; the intergenerational trauma caused by the Indian Residential School system; Métis resistances and Métis scrip; the hardships imposed by the forced Inuit relocations; the fostering out and adoption of Indigenous children during the Stolen Generation (Sixties Scoop); and the underlying causes and events that fueled the Oka Crisis.

Module 4: Contemporary Realities

Lesson 1 : We Reap what We Sow

Despite Canada's attempts at genocide, displacement, forced assimilation, and colonization, Indigenous peoples are still here. In this lesson, you will explore how the past informs the present; the consequences of colonial laws and policies on Indigenous peoples; why Indigenous peoples continue to lag behind on all indicators of health and community wellbeing; and the ever-present reality of racism in Canada today.

Lesson 2: The City is Home

Indigenous peoples leave the reserve, move south, or migrate to cities for a variety of reasons. This Lesson discusses the realities faced by First Nations, Inuit and Métis who live in urban settings; how they remain connected to culture, language, and land; and the importance of the Friendship Centre movement for connection, support and program and service delivery.

Module 5: Relationship-building with Indigenous Peoples

Lesson 1: Worldviews and Cultural Values

This Lesson discusses some of the rich and diverse cultural values and traditions of First Nations, Inuit, and Métis in Canada, and describes how these shape and influence Indigenous perspectives and practices today.

Lesson 2: Increasing your Engagement IQ

This Lesson provides some suggestions on how to work and communicate with Indigenous colleagues and partners, and strengthen your relationships with Indigenous peoples - a process we call increasing your Indigenous Engagement Quotient (IQ).

Module 6: Towards Truth and Reconciliation

Lesson 1: Rights and Resurgence

This Lesson discusses the growing assertion of Aboriginal and Indigenous rights, including the Federal government's White Paper of 1969, the creation of modern treaties, the emergence of movements like Idle No More, recent Supreme Court of Canada cases, the growth of self-government, and the United Nations Declaration on the Rights of Indigenous Peoples. These are all milestones in the recognition and evolution of Aboriginal rights.

Lesson 2: The Path Forward (15 minutes)

Truth comes before reconciliation. The truth is that Canada must reckon with its colonial past, and the devastation this has caused to Indigenous peoples. But Indigenous peoples are still here, and are showing the way forward. In this final Lesson, you will learn what true reconciliation can look like, and about First Nations, Inuit and Métis individuals, communities, and governments leading efforts in different sectors. There are examples of Indigenous and non-Indigenous people coming together in what Elder Marshall calls 'two-eyed seeing'. You will be introduced to the findings and recommendations of the Royal Commission on Aboriginal Peoples, Truth, and Reconciliation Commission, the investigation into Missing and Murdered Indigenous Women and Girls, and other landmark documents that point to clear Calls to Action. While progress has been made, there is still much work ahead on this path.

Clients and Testimonials

The Path online has been offered to more than 30,000 people, representing more than 100 clients. including provincial and national corporations, government departments, municipalities, and organizations.

“I considered myself well informed, but there was so much I did not know. With the recent awakening to the Residential School horrors, I had a heavy heart and not much hope. After taking this course, I feel empowered to learn from and work with Indigenous individuals and communities; to be an Ally in bringing about needed change.” ***Path*** online learner

“NVision’s course for BIRD Construction introduced the Indigenous peoples in Canada from coast to coast to coast. BIRD recognized the importance of employee diversity, inclusion, and the important role the Indigenous communities play in BIRD’s marketplace across the country—NVision’s ***The Path*** met our needs brilliantly. The NVision team was easy to work with and used a collaborative approach with BIRD’s management to develop the course material and to provide a range of delivery solutions to fit our structure. It was a great experience.” BIRD Construction

“The CBA is proud of its collaboration with NVision. Our partners in the company are incredibly flexible, responsive, and expert, and the quality of ***The Path*** is unmatched. The work we have done together represents a really important step forward in our reconciliation journey as we seek to know more and do better.” Canadian Bar Association

“My employer gave me the opportunity to do's ***The Path*** training (available also in French, on request) and it really was a reveal. I understood more things in three hours than my whole life. I realized that what I had learned in school, my life experiences, and the stubborn biases I grew up with were embroidered with a thread of cleverly studied and chosen lies. Reality is all different. And until this gap is bridged, as long as a real political will to correct the facts, we cannot hope for peaceful coexistence with indigenous nations in the next few years….thank you.” ***Path*** online learner

“The entire course is valuable and should be mandatory for all. The part that meant the most to me is about the residential schools, 60s scoop, etc. It is very disturbing that these things happened and yet I never learned about them in school. I wish I could help to make things right.” ***Path*** participant

“You took a remarkably complex Lesson and clearly, succinctly and quickly conveyed some of the most relevant and important topics for Canadians to understand.” ***Path*** online learner

For More Information

Jennifer David I thepath@nvisiongroup.ca I 613-237-3613

Web site: The Path: Your Journey Through Indigenous Canada

- **San'yas Indigenous Cultural Safety Online Training, San'yas Anti-Racism Indigenous Cultural Safety Training Program:**

  https://sanyas.ca/courses/manitoba/manitoba-core-ics-health

- **Indigenous Health Program, Rady Faculty of Health Sciences – Max Rady College of Medicine Syllabus:**

Medicine Longitudinal 2024-2025 - Course Name: Indigenous Health

Course Leader

Dr. Mandy Buss
Indigenous Health Course Leader
Mandy.Buss@umanitoba.ca

Course Coordinator

Tanya Walsh
Indigenous Health Curriculum Coordinator
Tanya.Walsh@umanitoba.ca

Course Administrators

Indigenous Health 1
Nadine Allain
Year 1 Course Administrator
260 Brodie Centre - 727 McDermot Avenue
Year1UGME@umanitoba.ca
204-789-3864

Mae Reyes
Year 1 Course Assistant
260 Brodie Centre - 727 McDermot Avenue
Year1UGME@umanitoba.ca
204-789-3930

Indigenous Health 2
Frances Dang
Year 2 Course Administrator
260 Brodie Centre - 727 McDermot Avenue
Year2UGME@umanitoba.ca
204-977-5675

Megan Roche
Year 2 Course Assistant
260 Brodie Centre - 727 McDermot Avenue
Year2UGME@umanitoba.ca
204-789-3551

Course Overview

The goal of the Indigenous Health Longitudinal Course is to provide physicians-in-training with the foundation they will need in order to contribute to the improvement of health outcomes for Manitoba's First Nations, Métis and Inuit communities. Most of formal learning

in this subject occurs during Years 1 & 2 and during the Professional Development Course (PDC) in Clerkship. As a longitudinal course, concepts from the Indigenous Health course are integrated into other components within the curriculum.

The objectives, content and approach to the Indigenous Health Longitudinal Course has been developed in consultation with Indigenous communities in the Manitoba region to reflect local values and priorities. A variety of teaching methods will be used throughout the course, including facilitated dialogue, critical self-reflection, documentaries, assigned studies, clinical skills development, case work, community engagement and team-based learning.

The Indigenous Health course employs an approach to learning that is intended to foster critical analysis of the historical and contemporary processes and systems that contribute to the development and perpetuation of health disparities among First Nations, Métis, and Inuit peoples. Specifically, the course will examine how colonial-based oppression and racism impacts the health of Indigenous peoples; thus, the voice, perspectives, and experiences of Indigenous peoples are privileged throughout this course and its learning activities.

In addition to exploring the relevant issues, the course will also help facilitate the development of clinical skills to identify and address issues of colonial oppression when working with Indigenous patients and communities.

Course Objectives

The overall objectives for the Indigenous Health Longitudinal Course are as follows:

Course Objective	CanMEDs Role
Integrate knowledge of the social, cultural, historical, and political context of Indigenous peoples in the practice of medicine.	Medical Expert
Demonstrate a commitment to engage in dialogue and relationship building with Indigenous peoples to improve health outcomes.	Professional
Exhibit effective communication skills when working with Indigenous patients that incorporates critical reflection of one's biases and ensures patient safety.	Communicator
Evaluate the policies, processes and systems involved in the delivery of health care to Indigenous peoples, considering both Indigenous best practices and scientific evidence.	Leader
Collaborate with, and value the viewpoints of, Indigenous and non-Indigenous health professionals and healers in the provision of care for Indigenous patients.	Collaborator

Devise strategies for health advocacy with Indigenous peoples at both micro (patient/family) and macro (community/system) levels.	Health Advocate
Propose appropriate ways to work with Indigenous peoples to identify health priorities and interventions.	Scholar

Specific session objectives will be posted on Entrada.

Learning Resources

In addition to specific resources that will be made available on Entrada for teaching sessions, we work closely with the NJM Health Sciences Library to have Indigenous Health related resources easily accessible to students. First Nations, Metis and Inuit health information can be found in the Indigenous Health Toolkit: https://libguides.lib.umanitoba.ca/indigenoushealth/

While the Indigenous Health course provides some contextual and historical information to support learning in the specific topics covered in the teaching sessions, it is not possible to provide a comprehensive history of Indigenous peoples and colonization through the course. Students who are interested in exploring this topic in greater depth are encouraged to explore the following recommended resources:

- Colonization Road (documentary): https://www.nipissingu.ca/library/video-streaming-nipissing/humanities-and-social-sciences-videos/colonization-road
- Colonial history timeline: http://www.fngovernance.org/timeline/timelinewindow
- Cardinal, T. (2005). Our story: Aboriginal voices on Canada's past. Toronto: Anchor Canada. Available at UM Library: https://search.lib.umanitoba.ca/discovery/fulldisplay?docid=alma99137089490001651&context=L&vid=01UMB_INST:UMB&search_scope=MyInst_and_CI&isFrbr=true&tab=Everything&lang=en
- Vowel, C. (2016). *Indigenous writes: A guide to First Nations, Métis & Inuit Issues in Canada*. Winnipeg: Highwater Press. Available at UM Library: https://search.lib.umanitoba.ca/discovery/fulldisplay?docid=alma99149211787401651&context=L&vid=01UMB_INST:UMB&search_scope=MyInst_and_CI&isFrbr=true&tab=Everything&lang=en
- Daschuk, J.W. (2013). *Clearing the Plains: Disease, politics of starvation, and the loss of Aboriginal life*. Regina: University of Regina Press. Online access via UM Library: https://search.lib.umanitoba.ca/discovery/fulldisplay?docid=alma99149342442701651&context=L&vid=01UMB_INST:UMB&search_scope=MyInst_and_CI&tab=Everything&lang=en

For assistance with finding information on this topic area, please contact Janice Linton, Indigenous Health Liaison Librarian at the NJM Health Sciences Library (Janice.Linton@umanitoba.ca)

Textbooks

Text	Author
Anti-Racist Health Care Practice, 2009 ISBN: 978-1551303550 **RECOMMENDED**	McGibbon & Etowa
Structures of indifference: Indigenous Life and Death in a Canadian City, 1st ed. 2018 ISBN: 978-0887558351 **RECOMMENDED**	McCallum & Perry

Course Format

The Indigenous Health Longitudinal Course is divided into two components: Pre-Clerkship and Clerkship.

Pre-Clerkship Component:
The course sessions within Pre-Clerkship are organized around four thematic areas (see below). Many of the sessions involve small group learning activities and facilitated discussion/peer teaching.
Thematic areas:

1. **Colonization in historic and contemporary contexts:** Teaching sessions within this area focus on the impacts of colonization on Canadian society and its institutions, and on the health and well-being of Indigenous peoples.
   IH1 - Health and the Indigenous Family
   IH1 - Introduction to Indigenous Peoples and Health
   IH1 - Ethics in Indigenous Health

   IH1 - Racism as a Social Determinant of Health
   IH1 - The Legacy of Residential Schools
   IH1- Inter-Generational Trauma & Impacts on Sexual Health I
   IH1 - Inter-Generational Trauma & Impacts on Sexual Health II

2. **Health Systems and Policy:** Policy, legislation and systems that impact the health of Indigenous peoples will be examined in this theme of the course.
   IH1 - Health Status of Indigenous Peoples in Manitoba
   IH1 - Introduction to Policy in Indigenous Health
   IH2 - Medical Relocation

3. **Clinical contexts**: Sessions in this thematic area will focus on issues and skills that are relevant to the clinical relationship with Indigenous patients.

IH1 - Human Library
IH2 - Deconstructing Power and Stereotypes in the Clinical Encounter
IH2 - Patient Decision-making in the Indigenous Context I & II

4. **Contemporary issues in Indigenous health:** In-depth discussion of contemporary health issues facing Indigenous peoples in Manitoba.
   IH1 – Inter-Generational Trauma & Impacts on Sexual Health I
   IH2 - Youth Health Issues
   IH2 – Issues in Urban Indigenous Health I & II
   IH2 – Inter-*Generational Trauma & Impacts on Sexual Health II*

Clerkship Component:
The Clerkship portion of the Indigenous Health course focuses on the practical application of the foundational knowledge from the Pre-Clerkship component. Indigenous Health is situated within two areas of the clerkship curriculum:

1. **Transition to Clerkship (TTC):**
   PH4 - Language and Advocacy Services: In collaboration with the Population Health course, the Indigenous Health course provides an introduction to the WRHA Indigenous Health Patient Services.

2. **Physician Development Curriculum (PDC):**
   IH5 - Indigenous Health I: Advanced Communication Skills: This session focuses on developing practical skills for addressing issues of power imbalances and racial oppression in the clinical setting.

   IH5 - Trauma Informed Care: Learning to recognize the signs of trauma and apply the principles of trauma informed care.

   In collaboration with the Population Health Course, Indigenous Health is also situated in the advocacy series in PH5. PH5 - Advocacy in Indigenous Health has a specific focus on the particular issues, and opportunities for advocacy engagement in the context of Indigenous health.

Professionalism:
Throughout the Indigenous Health Longitudinal Course, we will be addressing a variety of challenging, provocative topics including racism, oppression, colonization, power, and privilege. We invite students to dialogue and ask questions both inside and outside the classroom on the topic of Indigenous health, while at the same time maintaining a respectful learning environment.

Students are asked to familiarize themselves with the Faculty's Professionalism policies that will be used as a guideline for conducting our teaching sessions:
http://umanitoba.ca/faculties/medicine/education/undergraduate/professionalism.html

Opportunities for Feedback in the Course

The Indigenous Health course provides session-based verbal feedback to students during tutorial sessions. The Course Leader and/or instructors are available for one-to-one feedback upon request.

Notice Regarding Collection, Use, and Disclosure of Personal Information by the University

Parts of this course may be recorded. Your personal information, such as your image, and questions or answers you pose during lectures, may be included in the recording. This information is collected under the authority of The University of Manitoba Act, and in accordance with UGME policy. Recorded lectures will be used by the University for the purpose of providing students with access to lecture content via Entrada.

Further information about the use and storage of recordings can be found in the Max Rady College of Medicine Undergraduate Medical Education Policy: Video Recording of Lectures

Your personal information will not be used or disclosed for other purposes, unless permitted by The Freedom of Information and Protection of Privacy Act (FIPPA). For general questions about the collection of your personal information, contact the Access & Privacy Office (tel. 204-474-9462), 233 Elizabeth Dafoe Library, University of Manitoba, Winnipeg, MB, R3T 2N2.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 18, 2024
BRIEFING NOTE

SUBJECT: Restorative Practices Program

BACKGROUND:

At its September 25, 2024 meeting Council authorized CPSM management to commence the development and implementation of the Restorative Practices Program.

The Restorative Practices Program (RPP) 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 the Council, registrants, CPSM staff, and our many stakeholders and collaborators.

The Standard of Practice - Practicing Medicine to Eliminate 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, which is currently underway, is hiring a Program Director (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

Successful implementation of the Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism will require an operationalized Restorative Practices Program.

COUNCIL MEETING
DECEMBER 18, 2024
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Manitoba Prescribing Practices Program (M3P) – Codeine

BACKGROUND:

The Manitoba Prescribing Practices Program (M3P) is a program adopted by the CPSM Council and the Council of the College of Pharmacists of Manitoba (CPhM). It is a provincial prescription monitoring program, specifically intended to minimize the risk of diversion for several high-risk drugs that fall under the federal Controlled Drugs and Substances Act (CDSA). A key component of the program is the M3P schedule that lists these drugs.

When a drug is listed on the M3P schedule the prescription must (in accordance with section **5.8(2)** of the CPSM General Regulation):

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

The Standard of Practice – Prescribing Requirements has the following requirements for prescribing M3P drugs:

> **7. Manitoba Prescribing Practices Program (M3P Drugs)**
>
> **7.1.** Physicians must prescribe the drugs listed on the M3P schedule in the manner prescribed in the Regulation and this Standard.
>
> **7.2.** Section 7 of this Standard does not apply to:
> **7.2.1.** prescriptions for drugs administered in a personal care home as described under the Manitoba Health Services Insurance Act;
> **7.2.2.** prescriptions for drugs administered in a hospital or institutional residential healthcare facility; and
> **7.2.3.** the direct administration of a designated drug to a patient by a prescriber.
>
> **7.3.** All prescription drugs on the M3P Schedule must be written on a prescription form as is approved by CPSM.

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

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

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

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

In March 2022, CPSM Council approved the addition of tramadol and all tramadol-containing products to the M3P schedule. At this time, Council also expressed grave concern about the harms associated with codeine prescribing. **In Manitoba, the prescribing of codeine remains more prevalent than any other opioid and it continues to contribute to more accidental overdose deaths than any other opioid**. Tylenol #3 is not currently on the M3P drug list due to a variety of historical reasons. Council felt strongly that this issue needed to be evaluated and addressed in future collaboration with the CPhM. Furthermore, Council was concerned that the regulatory changes around tramadol may create the unintended and erroneous perception that codeine is a "safer" opioid. This is not the case. All opioids have associated benefits and harms.

The addition of codeine to the M3P schedule was extensively discussed by the Prescribing Rules Working Group. The Group's recommendation was to add non-exempted codeine products to the M3P schedule. The addition of a drug to the M3P schedule requires approval from both CPSM and CPhM Councils.

The CPhM Council approved at its September 27, 2024, meeting adding non-exempted codeine products to the M3P schedule. Effectively this would mean adding products such as Tylenol #2 and Tylenol #3 to the M3P schedule as Codeine Contin, Ratio-Emtec, Lenoltec #4, Tylenol #4 and Tylenol with Codeine Elixir are currently on the schedule. Exempted codeine products such as Tylenol #1 would not be added to the M3P schedule to maintain patient access for acute pain management, especially after hours and on weekends.

In the 2023-24 CPSM Annual Report, Dr. Shenouda stated:

> "One pending item to review is the addition of codeine to the list of Manitoba Prescribing Practices Program (M3P) medications. This will not be completed without consultation."

Council will have to approve sending the matter of adding codeine to the M3P schedule for 30-day consultation.

IMPACT:

Adding non-exempted codeine such as Tylenol #2 and Tylenol #3 to M3P schedule will impact registrants' prescribing:

- **Verbal prescriptions will no longer be permitted**.
- **Physician Assistants and Clinical Assistants will no longer able to prescribe** these codeine products to outpatients. PAs and Cl As currently require a co-signature from their supervising physician to prescribe codeine products.
- **Prescriptions will have to meet M3P requirements** (would now require therapeutic indication, total quantity of codeine to be dispensed written in numbers and words, and only one drug per prescription form, i.e., a codeine prescription will require a separate page/sheet).
- **Prescriptions must be received by the pharmacy within 3 days** of issuance.

Addition of Tramadol to the M3P Schedule (March 2022)

The Authors of the Manitoba Opioid Atlas are working on updated data to reflect the current opioid prescribing trends in Manitoba. The updated information is not yet publicly available, but Dr. Reinecke will provide a preliminary verbal update on the impacts of adding tramadol to the M3P schedule for the period of March 31st, 2022 to April 1st, 2023.

CONCLUSION:

Adding non-exempted codeine to the M3P schedule is consistent with other Canadian provinces. It also underscores the need for conscientious prescribing and the implementation of universal safety precautions to mitigate the risks associated with codeine. It levels the playing field with other opioids.

Excluding Tylenol #1 from the M3P schedule will help maintain patient access to low-dose codeine products that may be prescribed by pharmacists.

The Prescribing Practices Program is planning to hire an additional consultant in the New Year to assist with expanded program demands (budget was approved December 2023).

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 18, 2024, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves consultation be sent out to registrants, stakeholders, and the public on whether non-exempted codeine products should be added to the M3P schedule.

The College of Physicians & Surgeons of Manitoba

Codeine M3P or Not?

With thanks and recognition:
Michael Wiebe, BSc. (Pharm), BSc. (Hons)
Analyst, Prescribing Practices Program, CPSM

Presenter: **Dr. Marina Reinecke MBChB, CCFP(AM), ISAM**
Medical Consultant, Prescribing Practices Program, CPSM

CPSM Council Presentation
December 18, 2024

Learning Objectives

1) Review what has happened to tramadol since adding it to the M3P program?

2) Briefly explain the M3P program and Current status of codeine

3) Understand the use of codeine in Manitoba

4) Argue why codeine should be added to the M3P Program

5) Discuss potential unintended consequences of adding codeine to the M3P drug list

The Manitoba Prescribing Practice Program (M3P)

A **Provincial Prescription Monitoring Program**

Intended to minimize the risk for diversion of narcotic and controlled drugs.

M3P Prescriptions must meet certain requirements including the **therapeutic indication** and the **total quantity** in numbers and words.

Since adding Tramadol to the M3P program end of March, 2022…

Codeine

- Is an **opioid analgesic** – metabolism varies
- Used primary for pain relief, cough suppression
- Codeine has similar side effects to other opioids (e.g., morphine) including dizziness, drowsiness/sedation, constipation, and “slowed” breathing
- Prevalent gateway drug for **opioid use disorder,** especially in the opioid naive

Codeine – Current State

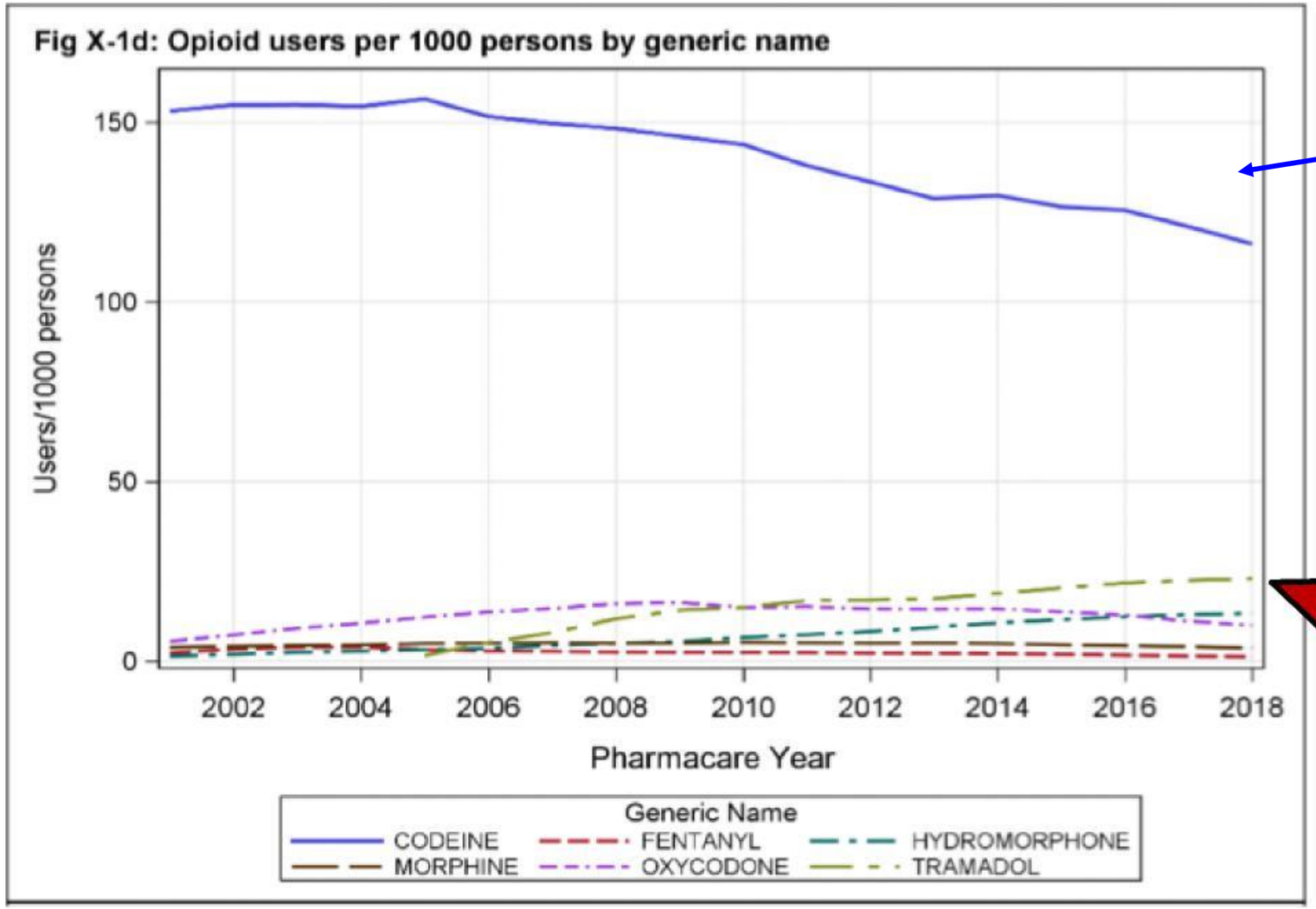
Several codeine products already M3P drugs:

- Codeine Contin
- Codeine IR
- Pure codeine syrup, etc.

Not part of the M3P Program:

- **Tylenol #3 – most prescribed opioid in Manitoba!**
- Tylenol #2
- Cotridin
- Exempted Codeine products (e.g., Tylenol #1)

Codeine Use in MB – Prescribing Data

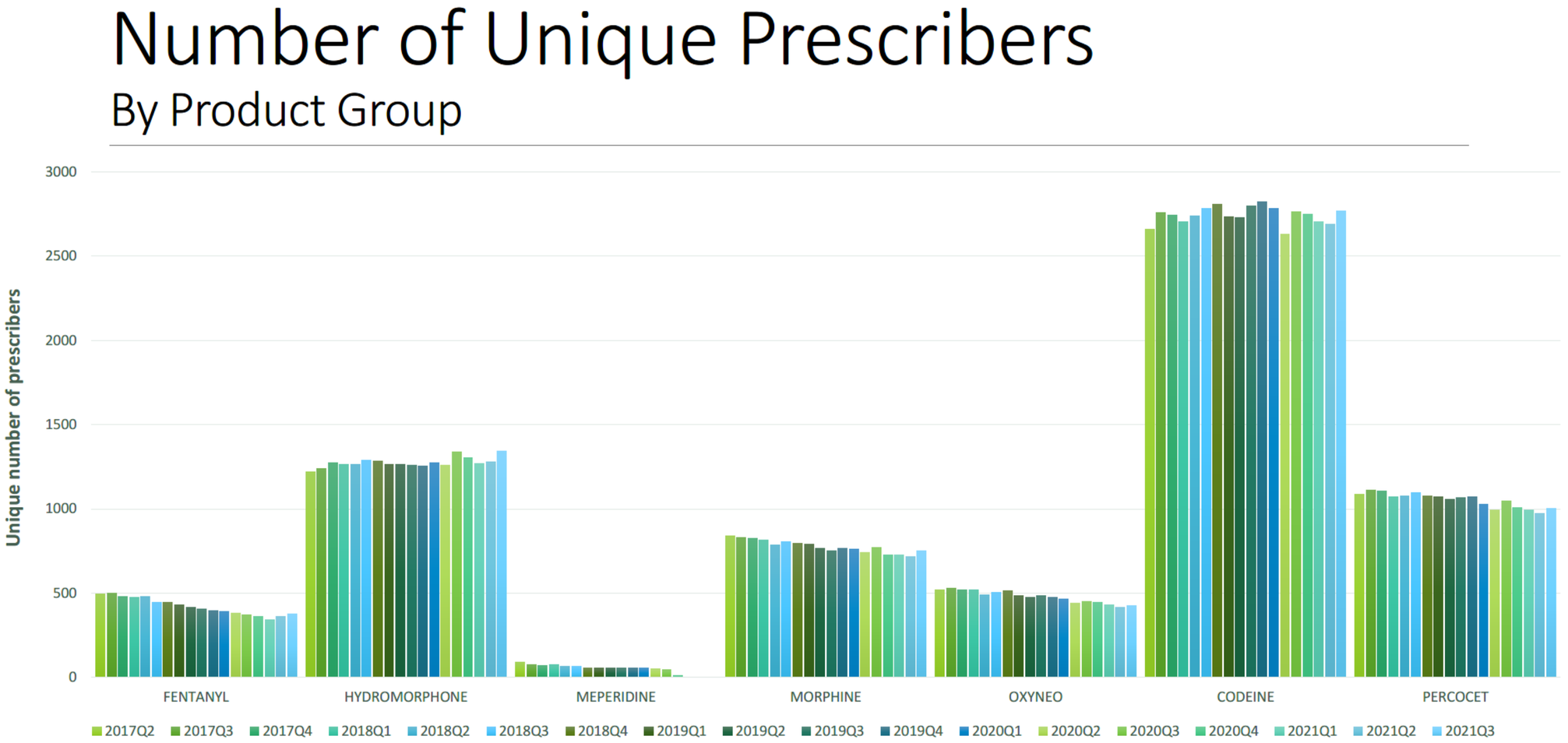


Codeine

Tramadol

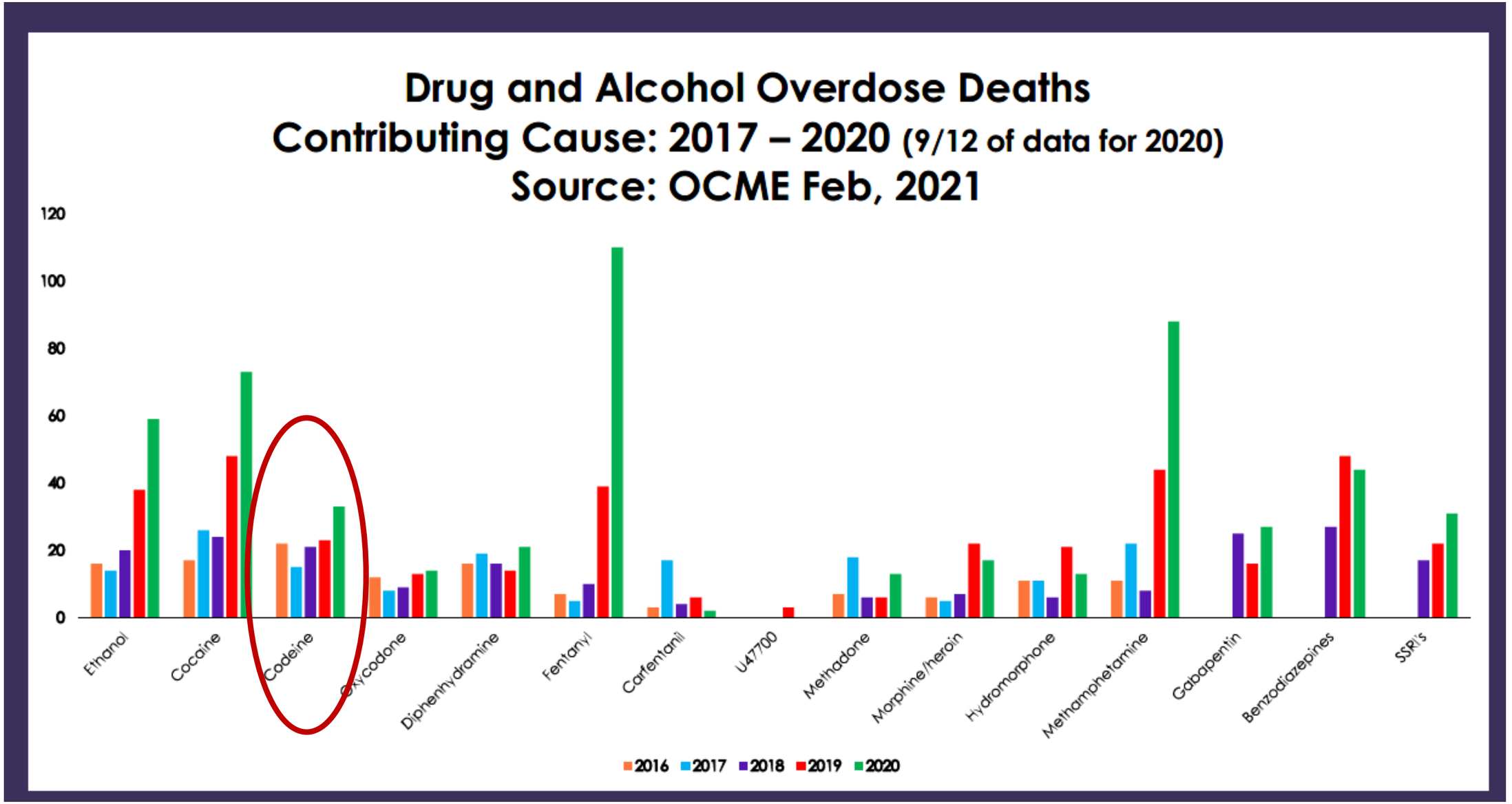
Adapted from the Manitoba Opioid Atlas

Codeine Use in MB – Prescribing Data



Reference: Manitoba Monitored Drugs Review Committee Biannual Trends Report (November 30, 2021)

Manitoba Death Data



Recommendation

PPP recommends that all codeine containing products be included under the M3P program, excluding exempted codeine products that may be prescribed by a pharmacist after conducting a patient assessment.

Rationale

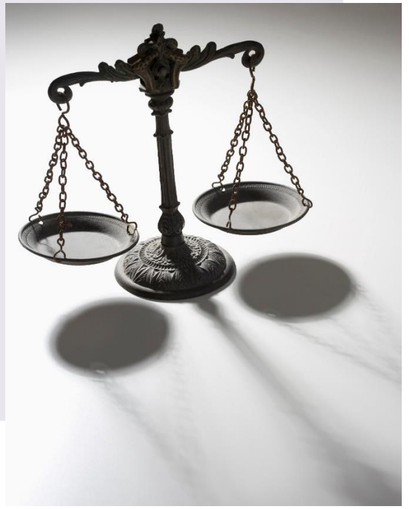
- Codeine is **not** a safer opioid
- When an opioid is prescribed, it should be selected based on a clinical assessment of the patient, their pain condition, and the characteristics of the opioid (not the type of prescription pad/requirements)
- This is consistent with all other opioids (with exempted products excluded to maintain patient access)

Recommendation

Rationale – Continued

- Balances the need for appropriate prescribing with access to assessment and treatment of acute pain
- In most provinces codeine is treated similarly to an M3P medication
- CPSM mandate:

  CPSM protects the public and promotes the safe and ethical delivery of quality medical care by physicians in Manitoba



Change Management

- All codeine products currently require prescribers to state the interval between part fills and the total quantity (no refills permitted)

- **Additional M3P Drug Requirements:**
  - ✓ No verbal orders, therapeutic indication,
  - ✓ Quantity must be written in numbers and words,
  - ✓ One drug per prescription, and
  - ✓ Must be received by the pharmacy within 3 days

- Increased phone calls/faxes to clarify prescriptions/ensure requirements are met
  - ✓ Clinical discretion may be required
  - ✓ M3P requirements generally better understood - CPSM fields many calls for inappropriately written Tylenol #3 prescriptions
  - ✓ Templates!
  - ✓ The CPSM Prescribing Practices Program can help

Unintended Consequences

- Undermanaged pain for patients
- Delays in patient care - hopefully temporary
- Clinical Assistants/Physician Assistants/some Residents (without a license number)
- Possible shift in patterns of diverted opioid use

Thank you!

COUNCIL MEETING
DECEMBER 18, 2024
BRIEFING NOTE

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

BACKGROUND:

Since the last Council meeting, the IMG Working Group met October 29, 2024. Participants addressed several key topics, including the content for a survey of the membership, components for a proposed orientation program for internationally trained physicians (ITPs), and the framework for a Standard of Practice for entering a new practice environment.

The IMG Working Group also discussed two recent studies from the CPSA and CPSS/SMA regarding ITPs entering practice and racism in the health care system, as well as recent studies from Manitoba that consider healthcare worker mistreatment in the province. The Manitoba studies are summarized as follows:

Racial Climate Survey (2023)

- *Developed by Shared Health Racial Climate Survey Working Group, and administered by CHI (n = 6677, approximately 13% response rate). Most respondents were clinical professionals. Physicians are not broken out.*
- *There are sub-reports for each SDO and information on subsequent recommendations and actions on their main webpage.*

Survey of Physicians in Manitoba (2022) (n = 1539, approximately 39% response rate)

- *Half (50%) of physicians and medical learners have experienced mistreatment frequently or sometimes. This mistreatment is based on race, ethnicity, gender identity, religion, sexual orientation or other personal attributes.*

Physician Abuse and Mistreatment: A Growing Concern (Dec 2021)

- *Half of the incidents were related to Covid. BIPOC, women, rural, family physicians more likely to experience mistreatment (n=403 (approximately 10% response rate).*

The working group's discussions underscored the urgent need for systemic change and enhanced support within the medical community.

In reviewing the draft survey, the group considered the need for accurate data collection regarding registrants' diverse educational and training backgrounds, especially for IMGs. Participants debated the best methods for data entry and the importance of categorizing IMGs to analyze differences in responses based on background. The group emphasized the importance

of clarity in survey questions to elicit high-value responses and proposed changes to streamline the survey process. Work on the survey continues.

Next steps include:

- Finalizing the survey.
- Deciding the medium of delivery for the survey (Survey Monkey vs. CPSM's portal).
- Components for the orientation program.
- Components for the Standard of Practice.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 18, 2024
FOR INFORMATION

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

Internal - People and Culture

- The Assistant Registrar for Quality Department position has been filled. After a competitive selection process, Sonja Bruin, MBA MBBS CCFP(EM), has been hired as Assistant Registrar of the Quality Department, effective November 25.

- Results from a Staff Engagement Survey were reviewed by the Senior Leadership Team. Areas with top-high scores included staff feeling they understood their purpose within the organization and having a strong commitment to quality. Areas to improve on were ensuring staff are equipped to know what is expected of them and recognition. Staff will meet by department for collaborative discussions and to review department-specific results and to create action plans.

- An all-staff meeting took place in November to share updates with staff and to provide an open forum for sharing their questions, feedback, or concerns. Performance conversations occurred organization-wide with the goal of more frequent check-ins with staff being built into ongoing conversations throughout the year.

- Ongoing discussions with senior leaders occur regularly to monitor progress on organizational priorities, identify and address any challenges.

External Relations

- Met or spoke with several individuals who raised concerns regarding their experience with CPSM in an effort to foster improved public perception.

- Delivered opening remarks and spoke on the topic of self-regulation at the Concordia Staff AGM and the Western Medical Universities AGM to audiences that included registrants.

- Co-hosted a webinar with Dr. Lisa Monkman, Chair of the CPSM Indigenous Advisory Circle, to support registrants' understanding of and to promote participation in the public consultation for the draft Standard of Practice for Eliminating Anti-Indigenous Racism.

- Met with the Honourable Uzoma Asagwara, Minister of Health, Seniors, and Long-Term Care, to provide an update CPSM's vision for medical regulation, common goals, and collaboration opportunities.

- Met with the Registrars from Medical Regulatory Authorities from B.C., Alberta, and Saskatchewan for knowledge sharing and to discuss priorities and emerging issues in the Western provinces.

- Responded to several media inquiries where they aligned with regulatory matters, including doing a radio interview that focused on CPSM's path toward Truth and Reconciliation.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
DECEMBER 18, 2024

FOR INFORMATION

SUBJECT: Performance Metrics Reporting

BACKGROUND:

2nd quarter 2024/25 performance metrics are shown as attached *Appendix A*. Metrics showing yellow or red, indicate the measure is outside expected performance parameters and variance explanations and course correction descriptions are included. You will note in the Quality section that certain metrics are shown as crossed out. This is either due to the metric being determined to not effectively measure performance or a new metric has replaced it or is under development. The deletion or replacement of metrics will be shown during the fiscal year but will not carry forward into the following year.

For both Registration and the Complaints and Investigations departments, metrics are under development and will be presented later in the fiscal year.

CPSM PERFORMANCE SCORE CARD		2024-25 2nd Quarter						
Performance Indicator	**Related goal/objective**	**Target in 2024/25**	**Baseline (last year)**	**2024-25 2nd 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 and Q2 - 7 Registrants between Age Triggered and Referred Audits had repeat reviews previously using the CSC Audit Decision and Feedback Framework Tool 57% stayed in the same CSC Outcome (#3 to #3 and #4 to #4) with improvement but still required further CPSM action 43% 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	Numbers are small due to repeat reviews. 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	26 Audits were completed in from Q1 and Q2 and the average was 22 days. There is 1 review that exceeded the 30 days which brings the percentage of audits completed to 96%	Monitor and measure	●	On target	
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	Average of 2.15 Days for Q1 and Q2	Monitor and measure	●	Exceeded target	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	64%	53%	Monitor and Measure	●	On target	Will continue to monitor and reassess targets after 2 years of data.
~~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 metric under development to replace "Response Time" above							
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)	69% of registrants have completed (1785/2594)	Adopt a standardized physician practice/ performance assessment framework	●		
QI process will be completed within targeted timelines 90% of the time for Category 1 (30 days), 2 OCR (110 days) and 3 (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 Category 1 – 30 days Category 2 – 110 days Category 3 – 240 days	90% completion for Category 1 – 30 days Category 2 – 110 days Category 3 – 240 days	Category 1: 100% Category 2: 29% Category 3: 33%	Monitoring and measuring	●	Category 2: 20 in progress, which includes waiting 30 days for their Action Plan after their Final Report Category 3: two in progress	Categories 2 and 3: will update the KPI to stop counting when the Final Report is issued, not when the Action Plan deadline passes.
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: 80% – 1 business day (target ↑ from 60% in 2023-24)	PPP responded to inquiries received Q1-Q4 (2023-24): 82% – 1 business day 89% – 2 business days 93% – 3 business days 100% – ≥ 4 business	PPP responded to inquiries received Q1 (May-Jul 2024): 83% – 1 business day 91% – 2 business days 91% – 3 business days 100% – ≥ 4 business days	NA	●	On target. By prioritizing response to inquires, PPP responded to 61% on the same day!	Will continue to prioritize response to prescribing advice inquiries. For 2024-25 will aim to maintain responsiveness of 80% within 1 business day (consistent with 2023-24 surpassed metric) and reach 90% within 2 business days (nearly met in 2023-24).

PPP will provide timely intervention for general prescribing advice inquiries with significant risks identified	Prioritize inquiries with significant risks identified (to the patient, public, and/or provider) to promote patient/public safety and to provide timely support to registrants.	PPP will offer intervention for inquiries with significant risks identified along a risk continuum: 80% of high-risk cases – 1-2 business days (urgent/highest risk cases dealt with same day) 80% moderate-risk cases – 1-2 weeks	New metric for 2024-25. Not tracked 2023-24.	PPP offered intervention for inquiries with significant risks identified along a risk continuum: 89% of high-risk cases – within 1-2 business days (highest risk cases dealt with same day) 95% moderate-risk cases – within 1-2 weeks	NA	●	On target/exceeding target. In fact, 85% of inquires with moderate risk are provided advice/intervention within 1-2 business days, similarly to high-risk cases.	Will monitor metric over fiscal year (since only Q1 data) to evaluate how metric/targets should evolve.
PPP will survey registrants/other health care providers who seek prescribing advice to identify opportunities for program growth	Evaluate PPP's ability to positively engage with registrants, to promote practice improvement (quality assurance), and to identify opportunities for program development.	75% of surveys will rate the overall impact of PPP interventions as neutral to positive on a Likert scale i.e., average score of Likert scale responses is rated as ≥ 3	New metric for 2024-25. Not tracked 2023-24.	Data analysis planned for December 2024 once sufficient number of surveys returned to maintain anonymity and for data significance	NA	**TBD**	Outcome evaluation via survey started in March 2024. Metric tracking pending collection of sufficient number of surveys to maintain anonymity and for data analysis/significance. Currently 56% response rate (24 responses/43 surveys sent) – Data analysis planned for Q3 (December 2024).	Will continue to send surveys and analyze data in Q3 (December 2024).

~~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~~	~~4/5 ME cases for Q1-Q4 with serious prescribing concerns closed this fiscal year. All cases with serious concerns took at least ≥120 days to complete.~~	~~Metric not tracked into 2024-25 as confounding variables delay case closure. ME Program on hiatus until MOU signed with ME office. PPP will continue to prioritize work on ME cases with serious prescribing concerns when program resumes.~~	~~NA~~		~~Metric not met 2023-24 as awaiting responses from registrants implicitly delays ability to close cases (for each correspondence, registrants have up to 30 days to respond). Access to ME office on hold for >12 months, awaiting MOU. Also limited by Medical Consultant time for multistep case review process.~~	PPP to focus on new KPIs for 2024-25 that similarly prioritize high impact regulation to promote patient safety and to support registrants.
Accreditation Programs								
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	31 of 36 inspections occurred that were listed in the Quarterly Reports to the provincial government (1 April 2024- 30 June 2024). 2 NHMSF inspections were completed in the period May1- July 31 2024.	Monitoring and measuring		86% of inspections were completed as indicated in the quarterly reports to the provincial government. The 5 inspections that did not occur was due to flight cancellation due to weather. Note: an additional inspection "to open" was done for a public diagnostic facility in order for them to be able to provide services.	Human Resources has recently been increased to support site inspections. Addition of new positions - permanent part time (ppt) LAB/TM (0.6 FTE) inspector (December 2023). PPT Radiology inspector (0.6). PPT clerk to support MANQAP (0.6) and temporary full time clerk position 7weeks to support MANQAP was hired.

~~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~~		~~Our largest uncontrolled variable is the timeframe it takes for the hospital to releases the requested patient chart (up to 6months). Consultant reviews are more predictable and inhouse staff do meet the 14 day completion rate.~~	Human Resources continues to be an issue for APO output. APO reports continue to increase 3 fold in 2024-2025. The addition of 2 nursing consultants with IPAC qualitification were hired with no scheduled hours (both individuals maintain fulltime employment making accessiblity to them limited). Training/ onboarding continues to support the increase in reports received.
MANQAP completion of 24 temporary status site accreditations accumulated since Covid to meet compliance with the Continuing Service Agreement MB	Protecting the public and contract compliance	2 inspections per month including lab/TM & diagnostic imaging projected to be completed by the end of 2024-25 fiscal year	Not currently measured	All facilities have been inspected that were listed in the Q1 report to the provincial government.	Monitoring and measuring		12 months to complete 24 sites was ambitous. Continued efforts to coordinate inspectors and site visits continue. Anticipated surplus request is still pending to financially support ramp up.	Human Resources has recently been increased to support site inspections. Addition of new positions - permanent part time (ppt) LAB/TM (0.6 FTE) inspector (December 2023). PPT Radiology inspector (0.6). PPT clerk to support MANQAP (0.6) and temporary full time clerk position 7weeks to support MANQAP was hired. Completion of onboardign is expected in 3rd quarter allowing for increased capacity to complete temporary status sites

Monitor and measure MANQAP implementation of the new WCAA Laboratory and Transfusion Medicine rollout.		40 sites projected to be inspected	Not currently measured	Survey is distributed to sites that have received full accreditation status. 12 sites have been completed with new standards, survey is in draft with communication and will be sent to approved location shortly.	Monitoring and measuring	●	Targeting 40 sites annually for 24-25 was overstated. The projection did not take into consideration that full accreditation status could take upwards to 8 months between PRC meetings. Four sites have full accreditation in this cycle	Reduce expected number of accreditation completion to full. 12 lab/TM/PSC sites that have been involved in accreditation cycle May 1-July 31have been completed, all 12 sites are currently in their 90 day remeadation timeline.
Performance Indicator	**Related goal/objective**	**Target in 2024/25**	**Baseline (last year)**	**2024-25 2nd Qtr**	**FIRMS**	● ● ●	**Variance Explanation**	**Course Correction**
COMPLAINTS & INVESTIGATIONS								
Under Development							All Metrics under review for 2024-	Significant overhaul in process and measures
Performance Indicator	**Related goal/objective**	**Target in 2024/25**	**Baseline (last year)**	**2024-25 2nd Qtr**	**FIRMS**	● ● ●	**Variance Explanation**	**Course Correction**
REGISTRATION								
Under Development							All Metrics in Registration under review for 2024-25	Significant overhaul in process and measures will be implemented in 2024/25

Performance Indicator	Related goal/objective	Target in 2024/25	Baseline (last year)	2024-25 2nd Qtr	FIRMS	● ● ●	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 •Total Reserves at 70% of annual operating expenses	•Debt to Equity ratio of 0.7 •Reserves @ 66% of annual operating expenses	•Debt to Equity reported annually •Reserves @62% 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 fiscal year-end
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 ($307,000) for the 6 months ending Oct 31, 2024 .	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 65% or 3.25/5.0	28% or 1.4/5	53% or 2.6/5	Adopt an enterprise wide cyber security policy and monitoring system	●	Plan shows CPSM will reach the target by year-end	Plans currently in place will allow CPSM to meet or possibly exceed the target by year-end
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	Project tracking and reporting monthly to SLT	NA	Project intake process and monitoring process has been implemented - reporting on track for 2024/25	Monitoring & measuring	●		

High IT responsiveness	Effective issue tracking, management and reporting	Triage 95% IT issues within 1 business days of receipt	determining the baseline	94% 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 performed - Over 90% of staff responded. Overall engagement score of 4.14/5	Monitoring and measuring	●		Staff meeting in November shared the overall results - followup meetings with individual depts to be scheduled
Retention of staff	CPSM retains its valuable staff in order to delivery on its mandate	•Average Years of Service •# of Employees resigning from CPSM other than retirement	Avg YOS – 8 years Resignations – 0	Avg YOS - **5.4** Resignations - 1 (May 1 to Oct 31 time frame)	Human Resource planning	●	Additional positions will automatically reduce YOS. Retirement of long service employees in 2023-24 (30+ year	
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, 2024 to Oct 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								
Increase positive sentiment score in media	Improve public	Increase positive associations of CPSM in media coverage	Media coverage sentiment scores as of December 31, 2021: Negative – 8.1% Positive – 3.8%	Media coverage sentiment scores as of November 26*, 2024: Negative 7% Positive 59% Neutral 34%	Leadership – transparency and disclosure Measuring and Monitoring	●		

coverage by 20%	perception of CPSM.	through improved sentiment score.	Neutral – 88.1%	*Media Monioring platform we used changed how they monitor sentiment in this quarter, resulting in adding two scales of measurement. "Positive" and "trending positive" were measured as positive. "Negative and "trending negative" were measured as negative. Previous scales were positive/negative/neutral only.				
# 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	Public newsletter was launched, subscriber list is growing. Proactively reached out to members of the public who had concerns about CPSM.	Leadership – training/transparency			
# 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. - Assess engagement metrics.	One webinar (for registrants) was hosted in 2022.	Hosted a webinar for registrants on the draft Standard of Practice - Practicing Medicine to Eliminate Anti-Indigenous	Leadership – training and transparency			

COUNCIL MEETING
DECEMBER 18, 2024

FOR INFORMATION

SUBJECT: **Operational Reports**

STAFF MATTERS

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

Quality Department – Dr. Sonja Bruin has accepted the position of Assistant Registrar for the Quality Department effective November 25, 2024.

Restorative Practices Program – Two positions have been posted; Medical Consultant (0.6 EFT) and Coordinator (1.0). It is anticipated these positions will be in place January 2025.

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 assets to support communications campaigns, and media relations.

Initiatives this quarter included:

- Finalizing and publishing the 2023-24 Annual Report.
- Supporting the launch and communications of the public consultation for the draft Standard of Practice for Practicing Medicine to Eliminate Anti-Indigenous Racism, including a webinar for registrants.
- Contributing to the development of a survey for the IMG Working Group.
- Developing communication components for several strategic initiatives.
- Communications issued to registrants in the fall included a special edition of the newsletter for registrants dedicated to content relating to information and resources on anti-Indigenous racism and honouring National Day for Truth and Reconciliation, advice on latex allergy risk management and harm prevention, mitigating risk when using Insulin Pump Therapy, new Assistant Registrar of Quality announcement, National Physician Assistant Day acknowledgement.
- Completing new sections on the website dedicated to information and resources for Preparing for a Leave of Absence, Retirement, and Closing or Relocating a Medical Practice.
- Developed guidelines for third-party content-sharing requests.

- Responding to several media inquiries where they aligned with regulatory matters.

FINANCE

Year to date financial results - For the 6 months ending October 31, 2024, CPSM has posted a net surplus of $307,000 vis-à-vis budgeted deficit of $105,000. Revenues and Expenses produced favorable variances of $133,000 and $279,000, respectively. The positive expense variance is primarily from manpower cost savings driven by temporarily vacant budgeted FTE's.

Implementation of Electronic Funds Transfer - CPSM has successfully carried out the substantive roll-out of the electronic funds transfer (EFT) payment initiative on October 1, 2024. Vendors and staff are now receiving payments by EFT instead of cheque. This significantly diminishes the risk of cheque frauds (cheques are still issued for one-time vendors). The final phase will involve honoraria recipients and is planned to roll out early in the new year.

INFORMATION TECHNOLOGY

The IT Team is heavily involved in several ongoing projects;

- IMG working group survey – the plan is to have this available on the CPSM Portal.
- Building a digital platform for Quality Assurance – this project has multiple phases with a timeline of 18 months for completion.
- Creating a digital platform for the Accreditation team.
- Revising the CPC digital workflow and updating the report.
- Implementing a new element in the cybersecurity framework (Threat Locker). This service provides application control, making sure only the safe, approved applications run. It addresses the requirements of CIS Control 2, "Inventory & Control of Software Assets" and also contributes to addressing sub-controls 4.1, 4.6, 9.1 of the CIS control framework.
- Planning to roll-out Windows 11 to CPSM computers by end of January.

National Registry Project – CPSM went live with transferring publicly available data to the National Registry on November 20, 2024.

QUALITY DEPARTMENT

Physician Health Program (PHP)

- Since September 26, 2024, and as of November 18, the PHP has had 29 new referrals with 18 of those referrals remaining open for more follow-up/PHP involvement (2 of these open referrals are in the process of signing PHP undertakings).

- Since the start of the fiscal year (May 1), we have had 61 new referrals (slightly higher than last year's numbers at this time of 54).
- We currently have 45 active PHP undertakings (which includes the 2 pending ones).
- **PHP caseload: 131 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).
- Working to complete policies for Independent Medical Evaluations (by end of year).
- Will be conducting a review of the BBP undertakings to determine which are still relevant/appropriate.

Quality Assurance Program (QAP)

- Current number of audits to be scheduled in 2024 is 147.
- 48 reviews have been conducted and been reviewed by the Central Standards Committee. This total does not reflect the Provisional to Full Registration reviews.
- Currently there are 72 open files in various stages of the process:
    - Waiting for Pre-audit Questionnaire - 9
    - Waiting for Manitoba Health - 8
    - Difficult Review Process - 15
    - Audit Scheduled – 8
    - Alternative Review Process - 6
    - Going to CSC – 21
    - Retired or planning to retire by the end of 2024 - 5
- The 15 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, Health Issue, 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 (MSF). This has already started with one MSF almost completed and action plans and performance reviews have also been used as an equivalency to a chart review.
- 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, no access to charts or were deferred due to recent Quality Improvement involvement.

Quality Improvement Program (QIP)

- Work plan being finalized to meet the end of the first cycle which ends in December 2025.
- All specialties will begin participation by end of 2025.
- Auditor resources being used to assist Complaints/Investigations with case reviews.
- Dr. Liesel Möller, 0.40 FTE Medical Consultant, joined QIP on Sept 10, 2024.

Prescribing Practices Program (PPP)

- **Registrant Advice & Support**: responded to **36 general prescribing advice** inquires Sep-Nov (**197** GPA cases thus far in 2024). KPI metrics: 53% responded to same day, 83% within 1 business day, and 92% within 2 business days.
- **Outcome Evaluation**: Sending (anonymous) surveys to registrants/other HCPs who seek prescribing advice, to evaluate the impact of PPP interventions. **56% response rate** (24 responded/43 surveys sent since March). Evaluate data December 2024.
- **Prescribing Approvals**: Issued **4 Suboxone** & **2 methadone** approvals for OAT since June (current total 234 OAT prescribers). **1 pain/palliative methadone** approval since June (current total 70 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 Leadership to implement the prescribing rules changes effective June 1, 2024 - responded to 20 related inquires since. Addition of non-exempted codeine to M3P schedule under review, supporting SLT with same & implementation.
- **High Dose Morphine Milligram Equivalents (MME) Reviews**: Reviewing 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 process and initial cases identified for review starting December. Risk stratification will be used to design intervention toward quality assurance and safer prescribing practices.

Manitoba Quality Assurance Program (MANQAP)

- Continuing Service Agreement (CSA) 2024 2025 with Manitoba Health- signed - surplus request still pending
- Diagnostic Standards being adapted to Manitoba, to be presented to February PRC meeting for approval to implement new WCAA DI standards in April 2025
- Collaboration with Manitoba Dental Association continues, MOU draft shared with MDA-waiting on response from MDA Registrar
- Hyperbaric Oxygen Therapy Standards approved at PRC November 20
- Psychedelic Assisted Psychotherapy standards will be presented to PRC in February meeting or sooner for approval
- Pre inspection site visit completed for NHMSF Prairie Surgical- accreditation opening pending outstanding citations
- Communications finalizing survey for laboratory standards - to evaluate implementation of WCAA Laboratory standards
- MANQAP continues to work with IC on complaints
- APO submissions reached 54 this year to date compared to 28 last year
- Callie Farthing supporting MANQAP as temporary FTE until Dec 20

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The Complaints & Investigation is emerging from a period of high turnover with a renewed mission and focus. The past three months have been dedicated to reviewing existing processes and procedures in order to identify areas that can be improved and others that need to be reworked to keep up with operational demands.

Notable changes in the past quarter have included the first joint Investigation and MANQAP site assessment, which enabled C&I to leverage MANQAP's expertise in facility inspections to support our investigative needs. In a similar vein, C&I now has a formalized process to transfer files back and forth to the Quality Department as needed when certain criteria are met. For example, if a committee review determines a quality audit at some point in the future would be helpful to ensuring remediation is successful, then the expert auditors in Quality would be leveraged.

C&I has also been engaging with complainants and physicians who have used our process to better understand what is working and what is in need of review. At present this engagement has been undertaken opportunistically as a form of a pilot project to determine scope and extent of need. We will turn our attention to a more structured and defined engagement process in 2025 in order to guide our evolution efforts with the end users' needs in mind.

REGISTRATION DEPARTMENT

The Registration Department is in a period of transition following the departure of the previous Director and Coordinator in June. The new Coordinator and Interim-Director are transitioning into their roles. Consequently, the administration of the department has not been at full capacity and numerous policy initiatives have been slowed.

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, though further wording modifications targeting accessibility are contemplated. 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 certificates of practice and provisional registration.

The Board of Assessors had its second meeting in November 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.
- Continuing to support the MCC's AMR changes currently in process
- Developing a new 'Amendment Report' to assist Doctor's Manitoba.

COUNCIL MEETING
DECEMBER 18, 2024
COMMITTEE REPORTS
FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met via an electronic meeting on October 8, 2024 to adjourn the hearing of a registration appeal and in-person with virtual option on November 27, 2024. Most of the matters discussed at the November meeting appear on this Council Agenda. The October 16, 2024, meeting was cancelled.

The Executive Committee held Appeal Panels on October 25 and November 6, 2024. A total of 11 appeals of Investigation Committee decisions were considered.

Respectfully submitted by
Dr. Nader Shenouda
President, CPSM and Chair of the Executive Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

The committee met on November 26, 2024.

The audit plan for the coming year was reviewed with BDO. A presentation was also provided by BDO on Cybersecurity risk and the impact of artificial intelligence. The committee requested management to provide additional details on CPSM's cyber risk plan including it's cyber response plan as well as a risk registry at the February 2025 committee meeting.

Financial statements with variance explanations and investments were reviewed by the committee. CPSM's 6-month actuals are showing a positive variance of $307,000, management is forecasting a year-end deficit of approximately $200,000. The committee requested CPSM management to have the investment policy reviewed with our current investment consultants for options that may improve potential returns on investments going forward at the February 2025 Finance Audit & Risk Management committee.

Respectfully submitted by
Dr. Charles Penner
Chair, Audit & Risk Management Committee

INVESTIGATION COMMITTEE REPORT:

Fellow Council Members,

Since my last report to Council, the Investigation Committee has met 3 times (September 4, October 9 and November 13) and reviewed 25 cases:

No Further Action - 12
Criticism - 7
Advice - 4
Undertaking for Education – 2

As of today, there are 169 outstanding investigation cases.

Respectfully submitted by
Dr. Kevin Convery
Chair, Investigation Committee

COMPLAINTS COMMITTEE REPORT:

The Panels of the Complaints Committee have met five times since May 1, 2024:

- May 9, 2024
- June 6, 2024
- September 12, 2024
- October 10, 2024
- November 21, 2024

During this period, 85 cases have been closed. Resolution of these cases is as follows, including a comparison to the 2023 – 2024 full year.

Resolution of cases closed	**For the period** May 1, 2024 to Nov 21, 2024		**For the year** May 1, 2023 to Apr 30, 2024	
No further action	42	49%	77	52%
Advice	20	24%	43	29%
Criticism	11	13%	18	12%
Informal resolution	1	1%	1	1%
Referral to Investigations Committee	7	8%	4	3%
Cases withdrawn	3	4%	5	3%
Inactive	1	1%		
Total	**85**	**100%**	**148**	**100%**

A summary of total cases closed during the period, along with the number of outstanding cases is as follows. Results from the current seven-month period is compared with the previous 2023 – 2024 full year.

Cases closed during the period	**For the period** May 1, 2024 to Nov 21, 2024 (7 months)	**For the year** May 1, 2023 to Apr 30, 2024
Number of meetings	**5**	**11**
Outstanding cases, beginning of year	134	119
New complaints received during period	93	163
Total number of complaints	227	282
Outstanding cases, end of the period	153	134
Total cases closed during period	**85**	**148**

Respectfully submitted by
Ms. Lynette Magnus
Chair, Complaints Committee

PROGRAM REVIEW COMMITTEE REPORT:

Diagnostic Facilities:

MANQAP completed the accreditation cycle of Northern Regional Health Authority (NRHA) on-site inspections this quarter. This completion assists with decreasing MANQAP's accumulated backlog due to COVID.

In addition to the completion of NRHA, six backlogged inspections of diagnostic facilities were completed between September PRC and November PRC. Two new openings of diagnostic facilities and one opening of a NHMSF were also completed, resulting in a total of fifteen inspections for this quarter.

Non-Hospital Medical Surgical Facilities (NHMSF):

The Committee approved changes to the CPSM NHMSF Liposuction Standards. Some of the changes (clarifying terminology/wording) will need to be referred to the College of Physician and Surgeons of Alberta as per CPSM's agreement to use the NHMSF standards as part of the Western Canada Accreditation Alliance. However, changes to clarify the liposuction techniques requiring NHMSF accreditation and acceptable amounts of lipoaspirate removed in a single procedure at a NHMSF can be implemented at CPSM's discretion. A communication plan is underway which will include a newsletter article and mailing to NHMSFs Medical Directors.

The NHMSF Hyperbaric Oxygen Therapy Administration Standards were approved for use for CPSM NHMSF accreditation inspections. It is anticipated the first Hyperbaric Oxygen Therapy facility will be

seeking CPSM NHMSF accreditation in the near future. This will be the only facility in Manitoba to offer this therapy for the 14 recognized conditions as outlined by Health Canada - public or private.

Respectfully submitted by
Ms. Leanne Penny
Chair, Program Review Committee

BOARD OF ASSESSORS REPORT:

The Board of Assessors met on November 7, 2024. Two policies were reviewed and endorsed by the Board with some modifications: the first for Certificates of Practice, and the second for registration in the Specialty-Limited class. The Board also considered proposed revisions to the Practice Direction for Professional Practice and Inactivity, which it recommended to be distributed by Council for public consultation. The foregoing all appears on Council's agenda. The Board also considered one (1) application for registration referred to it by the Registrar.

Respectfully Submitted by
Dr. Alewyn Vorster
Chair, Board of Assessors

CENTRAL STANDARDS COMMITTEE REPORT:

Central Standards Committee (CSC) Activities for the year 2024

The CSC met March 15, June 20, and September 13, 2024.

QUALITY ASSURANCE (QA) AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2023

The CSC reviewed:

- 34 New and Repeat QA Age Triggered Reviews
- 35 New and Repeat QA Referred Reviews

The following outcomes were determined at CSC.

*43	#1 Outcomes (*Multiple doctors from one review three total)
*15	#2 Outcomes (*Multiple doctors from one review one total)
9	#3 Outcomes
2	#4 Outcomes
*2	#5 Outcomes (Multiple outcomes from one review)
2	Other – Full Practice Audit, Interactive Audit and More Information Requested
73	Total outcomes (multiple outcomes from 2 reviews resulted in a higher amount of total outcomes compared to the total number of reviews

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:

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.

Respectfully submitted by
Dr. Roger Süss
Chair, Central Standards Committee