March19, 2025 Council Meeting

Wednesday, March 19, 2025 | 8:00 a.m.

AGENDA

CPSM Office – Brown Room
1000 – 1661 Portage Avenue

Time		Item		Action		Page #
5 min	8:00 am	1.	Opening Remarks and Land Acknowledgment		Dr. Shenouda	
0 min	8:05 am	2.	Agenda – Approval			
0 min	8:05 am	3.	Call for Conflict of Interest			3
10 min	8:05 am	4.	Consent Agenda i. Council Meeting Minutes December 18, 2024 ii. New Council Policy for Provisional Family Practice Registration iii. Amendment to Council Policy for English Language Proficiency	For Approval	Dr. Shenouda	4
15 min	8:15 am	5.	Practice Direction for Professional Practice and Inactivity - Family Practice Obstetrics	For Approval	Dr. Shenouda/ Mr. Triggs	30
5 min	8:30 am	6.	CPSM Council Elections	For Information	Dr. Shenouda	36
60 min	8:35 am	7.	Review of Election Process	Facilitated Discussion	Ms. Dupuis	39
30 min	9:35 am	8.	Max Rady College of Medicine – Strategic Plan	For Information	Dr. Nickerson	44
20 min	10:05 am	9.	--Break--			
5 min	10:25 am	10.	Restorative Practices Program	For Information	Dr. Mihalchuk	97
20 min	10:30 am	11.	M3P – Codeine	For Approval	Dr. Shenouda/ Mr. Triggs	99
5 min	10:50 am	12.	IMG Working Group Update	For Information	Dr. Shenouda/ Mr. de Jong	117
10 min	10:55 am	13.	Amendment to Council Policy – Adding PRA Exemption for Registration in Provisional Specialty Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes	For Approval	Dr. Shenouda/ Mr. de Jong	118

Time		Item		Action		Page #
20 min	11:05 am	14.	Registrar and CEO Report • Performance Metrics Update • Operational Report	For Information	Dr. Mihalchuk	134
5 min	11:25 am	15.	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	156
30 min	11:30 am	16.	In Camera	For Discussion		
		17.	Review of Self-Evaluation of Governance Process-survey via email		Dr. Shenouda	
4 hours			Estimated time of sessions			

Regulated Health Professions Act

Duty to serve the public interest

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

CPSM Mandate

10(2) A college has the following mandate:

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

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

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

COUNCIL MEETING - MARCH 19, 2025
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 December 18, 2024

ii. Council Policy – New Council Policy for Provisional Family Practice Registration

iii. Council Policy – Amendment to Council Policy for English Language Proficiency

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves all items on the consent agenda as presented.

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Website: www.cpsm.mb.ca

MINUTES OF COUNCIL

Council of The College of Physicians and Surgeons of Manitoba met on December 18, 2024, at the CPSM Office with an option to join virtually via Zoom.

1. CALL TO ORDER

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

COUNCILLORS:
Ms. Leslie Agger, Public Councillor, virtually
Dr. Kevin Convery, Morden
Dr. Caroline Corbett, Winnipeg
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Wendy MacMillan-Wang, Associate Member
Ms. Lynette Magnus, Public Councillor
Dr. Rizwan Manji, Winnipeg, virtually
Dr. Jennifer McNaught, Winnipeg
Ms. Marvelle McPherson, Public Councillor
Dr. Lisa Monkman, Scanterbury
Dr. Peter Nickerson, Winnipeg
Dr. Charles Penner, Brandon
Ms. Leanne Penny, Public Councillor
Dr. Nader Shenouda, Oakbank
Dr. Alewyn Vorster, Treherne

MEMBERS: Dr. Joel Kettner

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

REGRETS:
Mr. Neil Cohen, Public Councillor
Dr. Chaitasi Intwala, Winnipeg

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. CHARLES PENNER, 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 provided an overview of how the Consent Agenda is used.
Dr. Shenouda asked if any Councillors wished to discuss any of the consent agenda items.
Mr. Triggs advised there were typographical errors in the Notice of Motion for the new Council Policy – Appeals from Investigations Committee when referencing the listing of Appendix A, B & C. The correction will be made and reflected properly in the online version of the agenda package.

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY MS. LEANNE PENNY:
CARRIED

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

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

5. CONSULTATION APPROVAL – PRACTICE DIRECTION FOR PROFESSIONAL PRACTICE INACTIVITY

An in-depth discussion occurred around ensuring language was more concise as well as revising the first paragraph in the Motion for Approval document to correct the word neonatal to prenatal care. This revision will be reflected in the online version of the agenda package.

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

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

6. PRESIDENT-ELECT NOMINATION

Pursuant to section 39a of The Affairs of the College Bylaw the Executive Committee nominated Dr. Kevin Convery for the office of President-Elect. There were no further nominations from the floor; Dr. Convery was appointed to the office of President-Elect effective June 25, 2024, by acclamation.

7. STANDARD OF PRACTICE – PRACTICING MEDICINE TO ELIMINATE ANTI-INDIGENOUS RACISIM

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY MS. LEANNE PENNY:
CARRIED:

Council approves the attached 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.

8. MANDATORY TRAINING - TRC

IT WAS MOVED BY DR. CHARLES PENNER, SECONDED BY DR. PETER NICKERSON:
CARRIED:

Council Approves:

1) All registrants, subject to clause 4, be required to complete one of the 4 education programs identified in the background section, or an equivalency approved by CPSM (thereafter 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.

9. RESTORATIVE PRACTICES PROGRAM

Dr. Mihalchuk advised a few applicants were received for the Medical Consultant position and several applicants were received for the Program Coordinator position. The goal is to have both positions filled by the end of January 2025.

--------BREAK---------- (was moved up to occur at 9:45 AM vs 10:15 AM)

10. M3P - CODEINE

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

Council approves consultation to be sent out to registrants, stakeholders and the public on whether non-exempted codeine products should be added to the M3P schedule.

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. REGISTRAR AND CEO REPORT/PERFORMANCE METRICS UPDATE/OPERATIONAL REPORT – FOR INFORMATION

Dr. Mihalchuk presented the Council with the three reports outlining the matters currently addressed at CPSM. No further discussion occurred after being presented.

13. COMMITTEE REPORTS – FOR INFORMATION

The following Reports were presented to Council for information:

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

No further discussion occurred after being presented.

14. IN CAMERA SESSION

An in-camera session was held, and the President advised that following motion is to be recorded in the minutes.

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

Council advises the Manitoba Alliance of Health Regulatory Colleges (MAHRC) that while it agrees with the principles contained in the draft Interprofessional Collaborative Care Practice Direction it cannot adopt it as a CPSM Practice Direction because the language of the document does not align with the stylistic approach for CPSM documents. The MAHRC is to be further advised that CPSM is currently reviewing its Standard of Practice – Collaborative Care and it is invited to contribute to the component related to Interprofessional Health Care Delivery.

There being no further business, the meeting ended at 11:40 AM.

_____
Dr. N. Shenouda, President

_____
Dr. A. Mihalchuk, Registrar

COUNCIL MEETING - MARCH 19, 2025

NOTICE OF MOTION FOR APPROVAL

SUBJECT: New Council Policy for Registration in Provisional Family Practice-Limited, Provisional Non-Practicing, and Assessment Candidate Family Practice 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. The focus of this project is on clarity, updating wording to be consistent with other policies, and organization. Limited substantive changes are being made to existing requirements.

The new Policy for the provisional registration of family physicians is attached as ***Appendix A***. This document is largely consistent with current policies and procedures. Most changes are to add explanatory notes. This Policy is intended to replace sections **2.2.1.**, **2.10** and **Schedule A** of the current Registration and Qualifications Practice Direction.

The new Policy has been reviewed and endorsed by the Board of Assessors. The Board considered policy wording for assessing post-graduate training and independent practice experience, though deferred a final recommendation. This section of the Policy indicates "*Current policy under review*" (it is anticipated that these revised provisions will be presented to Council at its June 2025 meeting).

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the attached Council Policy – Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes to be effective immediately.
>
> Sections **2.2.1**, **2.10** and **Schedule A** of the current Practice Direction - Qualification and Registration is repealed.

COUNCIL POLICY

Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes

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

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Preamble

This Policy relates to registration in the following classes:

- provisional (family practice-limited),
- assessment candidate (family 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 (family practice-limited) class

1.1. Purpose and overview

The provisional (family practice-limited) class allows for the registration of candidates who do not meet all Specific Requirements for full licensure (i.e., CCFP, successful completion of MPAP, CMQ certification, or registration under the CFTA). This applies to many internationally trained physicians, and Canadian trained physicians who have not obtained CCFP or CMQ certification.

Applicants for registration in the provisional (family practice-limited) class must satisfy the following requirements from the *CPSM General Regulation*:[2], [3]

- 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. 3.19, 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.[4] Additional requirements, including terms and conditions of registration and practice supervision, are imposed.

Unless exempt, applicants must have satisfactorily completed an Approved Assessment to be eligible for registration in the provisional (family practice-limited) class. Exemptions are described

[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] RHPA at s. 32(1).

[3] Subsection 3.2(1) of the *CPSM General Regulation* at point 8.

[4] CCFP or successful completion of MPAP.

below. An Approved Assessment may be completed while registered in the assessment candidate (family 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 (family practice-limited) class are set out at section 3.19 of the *CPSM General Regulation*:

3.19(1) An applicant for registration as a provisional (family practice-limited) member must

(a) establish that he or she holds

(i) a medical degree granted from a nationally approved faculty of medicine, 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 holds CFPC certification or is confirmed by the CFPC to be eligible for certification by the CFPC,

(ii) he or she holds Member Board certification in family medicine or is confirmed by a Member Board to be eligible,

(iii) he or she holds certification in family medicine from the Collège des médecins du Québec,

(iv) he or she has satisfactorily completed two years of post-graduate clinical training in family medicine that

(A) took place in one or more facilities that provide health care and are recognized by a national post-graduate training authority,

(B) was accredited with a national post-graduate training authority at the time he or she took the training, and

(C) is approved by the registrar,

(v) he or she has satisfactorily completed at least one year of post-graduate clinical training in family medicine that meets the requirements of subclause (iv) and has had a total of at least three years practice experience in family medicine in the preceding five-year period;

(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;

(d) if applicable, establish that he or she has engaged in the area of family practice that he or she intends to undertake in Manitoba within the approved time period;

(e) provide a description of the continuing professional development activities that the applicant was required to complete as a condition of authorization to practise family 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; and
(g) subject to subsection (2), establish that he or she has
(i) satisfactorily completed an approved family practice assessment, and
(ii) entered into a satisfactory arrangement with a practice mentor;
(h) [repealed] M.R. 171/2022.

1.3. Satisfactory post-graduate clinical training in family medicine

1.3.1. Current policy under review.

1.4. Practice experience in family medicine (ss. 3.19(1)(b)(v))

1.4.1. Current policy under review.

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

1.5.1. Applicants who do not meet the currency in practice requirement at subsection 3.19(d) of the *CPSM General Regulation* are not eligible for provisional (family 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*).

1.5.1.1. The currency in practice requirement is further described in CPSM's Practice Direction for Professional Practice and Inactivity.[5]

1.5.1.2. 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.[6]

[5] https://cpsm.mb.ca/assets/Policies/Professional%20Practice%20and%20Inactivity.pdf

[6] If an applicant does not meet both the currency in practice requirement (ss. 3.19(1)(d)) and the approved assessment requirement (ss. 3.19(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.

1.6. Assessment requirement (ss. 3.19(1)(g)(i)) and exemptions

Approved Assessments

1.6.1. Subsection 3.19(1)(g)(i) of the *CPSM General Regulation* states that, subject to available exemptions (see below), applicants for registration in the provisional (family practice-limited) class are required to establish that they have satisfactorily completed an Approved Assessment in family medicine.

1.6.2. Assessments that have been approved by Council are as follows:[7]

1.6.2.1. Western Alliance for Assessment of International Physicians.

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

1.6.2.3. Family practice including anaesthesia:

1. PRA-FP; and
2. the anaesthesia assessment **annexed as Schedule A**.

1.6.2.4. The practice ready assessment for family medicine used by the College of Physicians and Surgeons of Alberta.

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

1.6.2.6. Successful completion of the twelve (12) month Manitoba Licensure Program for International Medical Graduates (MLPIMG) will count as an approved assessment.

Exemptions to having to undergo an Approved Assessment

1.6.3. Subsection 3.19(2) provides exemptions to having to undergo and Approved Assessment:

> *3.19(2) An applicant is exempt from the requirement in clause (1)(g) (assessment and practice mentor) if the applicant establishes that one of the following criteria is met:*
>
> *(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 (family practice-limited) or provisional (academic — s. 181 faculty) member in good standing, or*

[7] In approving assessments, the main issue is ensuring confirmation of competency. A secondary goal is ensuring equivalency for what is required to obtain CFPC certification eligibility.

(B) was previously conditionally registered in the area of family practice under the former Act or was previously registered in the area of family practice under section 64 of that Act,

(ii) has either satisfactorily completed an approved family practice assessment 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 family practice;

(b) he or she holds CFPC certification or provides written confirmation from the CFPC that he or she is eligible for certification;

(c) he or she holds Member Board certification in family medicine 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 in family medicine from the Collège des médecins du Québec.

Candidates who have not completed an Approved Assessment

1.6.4. 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 (family practice-limited) class registration. However, they may be eligible for registration in the assessment candidate (family practice) class for the purpose of undergoing an Approved Assessment (see section 3.41 of the *CPSM General Regulation*).

1.6.5. For registration in the assessment candidate (family practice) class, applicants must meet all other requirements for registration in the provisional (family practice-limited) class, but for subsection 3.19(1)(g), and must establish that they:

1.6.5.1. have been accepted into an Approved Assessment, and

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

1.6.6. The assessment candidate (family practice) class is further described below.

1.7. Terms and conditions

1.7.1. Provisional (family practice-limited) class registration is time limited and subject to restrictions imposed by the Minister's certificate. Section 3.20 of the *CPSM General Regulation* provides:

3.20(1) A person may be registered as a provisional (family 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.

3.20(2) A person may be registered as a provisional (family practice-limited) member to practise in a specific geographical area or practice setting as specified in the person's ministerial certificate.

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

3.21(1) As a condition of registration, a provisional (family 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 CFPC certification; or
(b) obtaining the designation of "successful in the MPAP" in the area in which he or she is assessed.

3.21(2) As a condition of registration, a provisional (family practice-limited) member must have a practice supervisor.

1.7.3. Practice supervision must accord with the requirements of the Council Policy for Supervision of Provisional Registrants.[8]

1.8. Extension of provisional registration

1.8.1. 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 that 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.

[8] http://cpsm.mb.ca/

1.8.2. In accordance with section 3.71 of the *CPSM General Regulation*, the extension may be granted if the Registrar determines that the registrant 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:

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

1.8.2.2. In 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.

1.8.3. 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.

1.9. Conversion to another class

1.9.1. Registration in the provisional (family 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 registrant 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 (family practice-limited) class may also be converted to the provisional (non-practicing) class in certain specified circumstances. Conversion is governed by sections 3.74, 3.75, and 3.76 of the *CPSM General Regulation*, which provide:

> *3.74(1) If*
>
> *…(b) a provisional (family 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

…

(b) the provisional (family practice-limited) class;

…

may be changed by the registrar to the full (practising) class.

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

1.10. Cancellation

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

3.84(1) The registration of a … provisional (family 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 (family practice) class

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

To be considered for registration, applicants must establish they have 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 (family practice) class are set out at section 3.41 of the *CPSM General Regulation*:

> *3.41 The registrar may register an applicant in the assessment candidate (family practice) class if the applicant establishes that*
>
> *(a) he or she meets the requirements for registration as a provisional (family practice-limited) member in subsection 3.19(1) other than the requirements to*
>
> *(i) enter into a satisfactory arrangement with a practice supervisor under clause 3.19(1)(f), and*
>
> *(ii) complete an approved family practice assessment and enter into a satisfactory arrangement with a practice mentor under clause 3.19(1)(g);*
>
> *(b) he or she has been accepted into an approved family practice assessment; and*
>
> *(c) he or she has an employment offer to engage in family practice in a specific geographical area, or practice setting, that is approved by the minister.*

2.2. Accepted into an Approved Assessment

2.2.1. Council has approved the Practice Readiness Assessment - Family Practice ("PRA-FP") offered through the Manitoba Faculty's IMG Program.

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

2.3. Employment offer

2.3.1. CPSM will not accept an application for registration in the assessment candidate (family practice) class unless it is supported by an employment

offer to engage professional practice in a specific geographical area or practice setting that is approved by the minister.

2.4. Time limited registration

2.4.1. Registration in this class is time limited. Section 3.42 of the *CPSM General Regulation* provides:

> *3.42(1) A person may be registered as an assessment candidate (family practice) member for a period of up to three months, which may be extended in accordance with sections 3.71 to 3.73.*
>
> *3.42(2) The time period described in subsection (1) does not include the time period for the orientation program referred to in section 3.43.*

2.4.2. 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.

2.4.3. 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:

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

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

2.4.4. 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.

2.5. Terms and conditions

2.5.1. Registration in this class is restricted to a specific practice setting and professional practice and may be subject to having to do orientation.[9] Subsections 3.42(3) and 3.43 of the *CPSM General Regulation* provide:

> *3.42(3) A person may be registered as an assessment candidate (family practice) member to practise in a specific geographical area or practice setting.*
>
> *Condition of registration*
> *3.43 As a condition of registration, the registrar may require that an assessment candidate (family practice) member complete an orientation program within a time period approved in accordance with a national standard.*

2.6. Conversion to provisional registration

2.6.1. Subsection 3.77(2) of the *CPSM General Regulation* provides:

> *3.77(2) Upon successful completion of the approved family practice assessment, the registration of an assessment candidate (family practice-limited) may be changed by the registrar to provisional (family practice-limited) membership.*

2.7. Cancellation

2.7.1. Assessment candidate (family 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.*

[9] A candidate is not eligible for movement from the assessment class to registration in the family practice limited class until orientation, if required, has been completed.

3. Provisional (non-practicing) class

3.1. The provisional (non-practising) class is intended for provisional registrants who take a leave of absence but intend 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 provisional (gamily 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.*

Schedule A – Anesthesia Assessment

Low Risk Anesthesia Assessment Program
Department of Anesthesia
University of Manitoba

PREAMBLE

The College of Physicians and Surgeons of Manitoba (CPSM) 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 Manitoba Faculty.

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 provisional or assessment license from CPSM, and
- certification of non-specialist training from a program acceptable to the CPSM.

COUNCIL MEETING - MARCH 19, 2025

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Amendment to Council Policy for English Language Proficiency

BACKGROUND:

The government has issued a new regulation, coming into effect on March 26, 2025, that applies to English language testing requirements in Manitoba.

Section **10.1** of Manitoba's *Fair Registration Practices in Regulated Professions Act* states that a regulated profession (which includes CPSM) must ensure that it complies with any regulations made under the act respecting testing requirements for English or French language proficiency.

As a result, CPSM is required to update Council Policy for English Language Proficiency (ELP Policy) to comply with this new legal requirement.

The Language Proficiency Testing Regulation was registered on September 27, 2024, and comes into force on March 26, 2025. It can be found here: M.R. 91/2024, Language Proficiency Testing Regulation. The regulation requires that professions accept certain prescribed tests:

> ***2(1)*** *A regulated profession must accept the following tests from an applicant in order to satisfy the regulated profession's testing requirement for English language proficiency:*
>
> > ***(a) the Canadian English Language Proficiency Index Program (CELPIP) General Test;***
> >
> > ***(b) the International English Language Testing System (IELTS) General Test.***

The current ELP Policy requires **IELTS Academic**. IELTS Academic was chosen for the current ELP Policy as it is specifically designed for those who are looking to study at a university or college, or join a professional association where English is a prerequisite.

As indicated above, the new regulation requires that CPSM accept IELTS General in its registration process.

The new regulation also requires that, for combined test results, the profession must accept a combined test result from the applicant if the testing organization/institution that developed the accepted language test offers the option (e.g., IELTS One Skill Retake). Test results from at least 2 years prior must be accepted.

The Fair Registration Practice Office advised their focus is on reducing barriers and ensuring screening tools are necessary and reasonable. They noted that Ontario made the same change to their regulations, which came into effect in January of 2024.

Given the requirements of the new regulation, the ELP Policy needs to be amended. Proposed additions are <u>underlined,</u> and deletions are ~~struck out~~.

1. *English language proficiency testing*

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

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

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

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

Footnote 3 in the ELP Policy would change to say, '*This list is based on the FMRAC Model Standards for Medical Registration in Canada<u>, as modified to comply with Manitoba's Language Proficiency Testing Regulation</u>*'.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

Council Policy – English Language Proficiency be amended as presented effective March 26, 2025.

COUNCIL MEETING - MARCH 19, 2025

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Practice Direction for Professional Practice and Inactivity – Family Practice Obstetrics

BACKGROUND:

On December 18, 2024, Council approved consultation be sent to registrants, stakeholders, and the public on whether to amend the Practice Direction – Professional Practice and Inactivity to remove potentially confusing language related to Family Practice Obstetrics Requirements. The proposal would result in the deletion of section **7.3**:

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.*~~

On January 13, 2025, CPSM notified registrants, stakeholders, and the public of the consultation being open until February 18, 2025. A reminder was sent to registrants on February 5, 2025.

In total 17 responses were received - 13 from registrants, 2 from stakeholders, 2 from the public (retired physicians). (***See Appendix A***)

Of the 17 responses, 6 were in favour of removing section **7.3** from the Practice Direction (3 registrants, 2 stakeholders and 1 member of the public). The other 11 responses either expressed concern or confusion regarding what the proposed new Practice Direction would require.

To address the continued confusion, CPSM management sought advice from Councillors Dr. Carrie Corbett and Dr. Jennifer McNaught, both of whom practice Obstetrics & Gynecology.

It is recommended that sections **7.2** and **7.3** be replaced with the following:

> **7.2** Physicians registered to practice in the field of family medicine who have the knowledge, skill, and judgment to do so may provide general prenatal care to pregnant persons. When they identify a prenatal health issue that is beyond their knowledge, skill, and judgment to address, they must promptly refer the patient to a qualified registrant with the appropriate expertise.
>
> **7.3** Family practice physicians may provide intrapartum care (labour and delivery) if they have received post-graduate clinical training in intrapartum care and have practiced it within the past three (3) years.
>
> > **7.3.1** Family practice physicians providing intrapartum care must recognize the limits on their scope of practice in intrapartum care and refer complex or high-risk situations to a qualified registrant with the appropriate expertise.
> >
> > **7.3.2** However, family practice physicians without these qualifications may provide intrapartum care in an urgent situation (e.g. when the delivery is imminent and transfer to a qualified physician is not safe).

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> The recommended amendments to sections **7.2** and **7.3** of the Practice Direction for Professional Practice and Inactivity be approved as presented effective immediately.

Comment
In response to your email of Jan 16, 2025 re 7.2.2 • *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.* The differentiation between elective or planned deliveries and emergent deliveries should be made. I work in the emergency room and will continue to do emergent deliveries despite this practice direction.
[redacted] I agree with early referral practice and as soon as I see a pregnant patient, I immediately record her obstetrical history and order appropriate lab tests and arrange standard ultrasound At the same consultation refer the patient for obstetrical care The reality is that patients who are referred to appropriate GP obstetrical care are seen within 4 weeks, but patients who need specialist care, or wants to be seen by midwife, are often seen for the first time after 20 weeks. The reason being that there are just not enough of them In reality I look after patients beyond my personal comfort, but at least they get care Although not as it should be, but at least better than no care. I do all that is needed, but have to say that , like many other services like paediatrics, psychiatry and psychology, we as family physicians are left to catch the dropped ball and do the best we can. I do believe this new directive is going to create serious problems for our patients and ourselves. Yours Sincerely [redacted]
Thank you for your recent email on the proposed changes. 7.2.2 suggests that physicians who have not done deliveries in 3 years may not do deliveries. I do not have the whole context but should this state "should not do elective deliveries" as emergent deliveries in an open ER are always a possibility in our rural practice. If I, and my colleagues, are NOT TO DO deliveries then EMS must bypass our facility and go to the closest open ER with trained staff.

I agree with the amendment to the Practice Direction - Professional Practice and Inactivity- obstetrics
I'm afraid the wording of 7.2.1 is still unclear to me. Does "practiced obstetrics within the past three years" refer to intrapartum?
I am still confused with this statement: • 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. What does it mean to be registered with entitlement to practice obstetrics? If you have delivered babies for 20 years then decide to quit are you still registered to practice obstetrics? Or are you de-registered in which case you have to refer by 14 weeks. Or what about our residents who are trained well to practice obstetrics but then decide not to get privileges to deliver babies .....can then never do prenatals past 14 weeks after they graduate? I am also concerned about the 14 weeks. We are a small group [redacted] in Steinbach and we may not have the capacity to see everyone by 14 weeks and to do all the prenatals. We rely on the other family docs in our group to help us out.
I am writing this email seeking clarification regarding providing prenatal care to Low risk pregnant patients in my Family Medicine practice. My usual practice is to refer my low risk obstetrics patients to specialists at 20-24 weeks of pregnancy. I do not practice inpatient obstetrics and I take over care for my patients at 6 weeks post partum after they are discharged by specialist. Meanwhile I do provide ongoing support for these patients (as their family doctor) even during the time they are simultaneously seeing their specialist for their pregnancy. I am getting ambiguous information from this practice direction and would like some clarification so that I can provide the best informed care for my patients. Thank you! Best Regards, [redacted]
As a [redacted] in northern and remote practices with Ongomiizwin Health Services [redacted] we have a unique staffing model that includes PAs at level 5 who are supervised offsite remotely by family physicians. As extensions of them, PAs are not allowed to exceed the scope and abilities of their supervising physicians, which would have implications on impact on care the PA is able or not able to provide day by day. Because deliveries occur semi-regularly but with no predictability, it can be several years between them.

These deliveries that happen in community are not planned and generally, efforts are made to send pregnant patients out on confinement at 36 weeks. However, for complex reasons, either deliveries occur prematurely, or as an eventuality when women choose not to relocate to Winnipeg. Therefore, consideration might need to be made for family physicians working in more remote areas, that 3 years may lapse and they will be facing an imminent delivery, or a PA operating under them is. It would be unethical for the PA or physician to not want to help participate and assist in the case under these circumstances, as there's often only 2 nurses and a PA in the station, or 2 nurses who consult the on-call MD/PA and obstetrics. This unique scenario should be considered as there are likely similar models of care in rural facilities.
I have reviewed your email regarding Obstetrics and prenatal care for Family Physicians. I do provide prenatal care but hand off care to those that manage deliveries ie Obstetricians or Family Physicians with that scope in their practice. I am making an assumption that my current status remains acceptable but would like to confirm that with the CPSM.
I would agree with the proposed amendment, to remove section 7.3 from the Practice Direction-Professional Practice and Inactivity
I used to attend deliveries, giving it up long ago due to decreasing numbers and other considerations. The 7.2 to my eyes is different phrases but similar intetpretation: I should not be providing any prenatal care. My interpretation of 7.3 was that I could provide care up to 14 weeks but not beyond. Lawyers dont care about intention but what is written. Until this is sorted, I will get the routine testing and ultrasound balls rolling and refer early. I will not be filling out any prenatal forms until then if ever again. Best of luck getting the language right.
I agree to refer patients before 14 weeks if not with updated obs training Everyone must have updated training
Thank you for asking for my opinion regarding this matter as it relates to prenatal care. I had not responded to your earlier request as, after reviewing the information, I thought it sounds appropriate. But if you need comments that are other than negative, here is mine - this is fine, thank you for your hard work.
Comment
I have review both public consultation requests; Addition of non-exempted codeine products to the Manitoba Prescribing Practices Program (M3P), and Amendment to Practice Direction-Professional Practice and Inactivity. [redacted] has no concerns with either proposal.
Hello, on behalf of [redacted], we would like to state that the information provided for this consultation makes sense for the changes that are being proposed.
Comment
I would agree to both rules being changed as recommended by the College, requiring special prescriptions for all codeine medications and removal of time restrictions from the regulations regarding family practitioners involvement in obstetrical practice.

Regarding obstetrical referrals by non delivery qualified family docs , referrals could also be made to qualified midwives. Qualified docs could subsequently refer patients back to a nurse practitioner or to the original refering doctor to follow until around 36 weeks gestation in an uncomplicated pregnancy. To do less will cause great problems for rural patients. I base this on 40 years of looking after rural/ northern patients. They will not travel frequently enough for adequate care if the regulation does not take this into consideration.

COUNCIL MEETING – MARCH 19, 2025

FOR INFORMATION BRIEFING NOTE

SUBJECT: CPSM Council Election

BACKGROUND:

In accordance with the CPSM Affairs of the College Bylaw, elections for members of CPSM Council take place in the spring. This year elections are required for:

1. East Electoral District

   Dr. Kevin Convery who currently holds the seat has been elected to President-Elect which creates a vacancy necessitating a by-election to fill the seat for the remainder of the term that concludes in June 2026.

2. Associate Registrant

   Annual elections are held for the Associate Registrant seat. Dr. Wendy MacMillan-Wang is the incumbent.

In accordance with the Affairs of the College Bylaw, this year:

- The Notice of Election, including a voters list, nomination form and procedures for nominating will be sent out on March 18, 2025.
- Nominations are due on or before noon on April 8, 2025,
- Ballots will be sent out April 15, 2024.
- The deadline for voting will be noon on May 6, 2025.

The ballots and voting instructions are sent out via VoteNet and voting is done electronically through VoteNet.

See Appendix A for current Councillor Terms Listings. It should be noted it is theoretically possible that 9 of the current 18 Councillors may not be on Council as of July 1, 2026, as their terms will have expired or will face re-election:

- Dr. Jacobi Elliott (Past-President, terms ends June 2025)
- Dr. Carrie Corbett (Winnipeg, election June 2026)
- Dr. Lisa Monkman (North, election June 2026)
- Dr. Peter Nickerson (Faculty appointment, term ends June 2026)
- Dr. Wendy MacMillan-Wang (Associate Registrant, election June 2025)
- Mr. Allan Fineblit, K.C. (Government Appointee, term ends June 2026)
- Ms. Marvelle McPherson (Government Appointee, term ends June 2026)

- Ms. Leanne Penny (Government Appointee, term ends December 2024 but continues until new appointment is made)
- Ms. Lynette Magnus (CPSM Appointee, term ends June 2026)

Councillor Term Listing

Council Members	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	Start Date	End Date	Comments
Public Representatives																		
Agger, Ms Leslie																8-Jul-19	28-Jun-27	CPSM Appointed - 1st Appoomtment Jun 2019 - Reappointed Jun 2023
Cohen, Mr. Neil																26-Jun-24	26-Jun-28	CPSM Appointed - 1st Appointment Jun 2024
Magnus, Ms Lynette																16-Jun-18	22-Jun-26	CPSM Appointed - 1st Appointment Jun 2018 - Reappointed Jun 2022
McPherson, Ms Marvelle																13-Apr-17	2-Apr-26	Gov Appointed - continue - 1st Appointment Apr 2017 - Reappointed Apr 2022
Fineblit, Mr. Allan																30-Mar-17	2-Apr-26	Gov Appointed - continue - 1st Appointment Mar 2017 - Reappointed Apr 2022
Penny, Ms Leanne																17-Dec-19	1-Dec-24	Gov Appointed - continue - 1st Appointment Dec 2019 - Reappointed Aug 2022
Councillors																		
Shenouda, Dr. Nader(P)											X					6-Jan-16	19-Jun-27	President - Becomes Past President in June 2025
Penner, Dr. Charles (PE)																19-Jun-20	15-Jun-29	President-Elect - Becomes President in June 2025
Elliott, Dr. Jacobi (PP)																15-Jun-18	15-Jun-25	Past-President - As term is up June 2025 will no longer be a member of Council
Intwala, Dr. Chaitasi																26-Jun-24	26-Jun-28	Winnipeg
Manji, Dr. Rizwan																26-Jun-24	26-Jun-28	Winnipeg
McNaught, Dr. Jennifer																26-Jun-24	26-Jun-28	Winnipeg
Corbett, Dr. Carrie																22-Jun-22	15-Jun-26	Winnipeg
Convery, Dr. Kevin																15-Jun-18	15-Jun-26	East - Becomes President Elect June 2025
Monkman, Dr. Lisa																22-Jun-22	15-Jun-26	North
Vorster, Dr. Alewyn																26-Jun-24	26-Jun-28	West
Associate Member																		
MacMillan-Wang, Dr. Yushi																26-Jun-24	26-Jun-25	Elected Annually
University Appointed (Yearly)																		
Nickerson, Dr. Peter																1-Sep-22	28-Jun-26	
as of March 3, 2025																		

COUNCIL MEETING - MARCH 19, 2025

FACILITATED DISCUSSION BRIEFING NOTE

SUBJECT: Review of Election Process

BACKGROUND:

This agenda item is a facilitated discussion. Council is to discuss and explore issues related to reviewing Councillor elections. Success will be consensus on key components that will be the basis for a draft election model to be considered at a future Council meeting.

This document outlines issues that Councillors are to consider in preparation for a facilitated discussion.

CURRENT MODEL:

The Regulate Health Profession Act (RHPA) establishes that CPSM Councillors are either elected or appointed. Eight regulated registrants and one regulated associate registrant are elected. Six public representatives are appointed (3 by government and 3 by Council). One practicing physician who is a faculty member is selected by the Faculty of Medicine. Council is also comprised of a president and past-president.

The only RHPA election requirement is that the elected council members be "elected in accordance with the by-laws". Accordingly, flexibility exists to establish an election model that best helps attain the CPSM mandate.

Currently, the election of 7 of the 8 regulated registrants is based upon geographic location (electoral districts). Four registrants represent the Winnipeg electoral district, and the North, East and West electoral districts are represented by 1 registrant each. The 8th elected registrant is the President-Elect position that is elected by Council from the other 7 elected registrants.

To represent an electoral district, the registrant must, amongst a few other miscellaneous requirements, be on the voters list for that electoral district, and maintain their primary practice location in the electoral district.

The facilitated discussion will determine what are the components that make up a high-quality election model (if the allotted time is insufficient to come to consensus, the discussion will be continued at the next Council meeting).

DISCUSSION POINTS:

CPSM does not have a skill matrix that sets out the skills necessary for Council to carry out its duties and responsibilities. Similarly, Council does not have a skills inventory of its current councillors to determine what if any skill gaps exist.

Issue 1:

> Should Council have a skill matrix and inventory? Would this improve Council's performance and ensure effective governance?

Attached as ***Appendix A*** is *Board Profile – Behavioural Competencies, Unique Skills and Experiences, and Diversity Attributes Descriptions* developed in 2024 by the College of Physicians and Surgeons Ontario. (It is provided for illustrative purposes only. Council is not being asked to develop or approve a skill matrix; it is only being asked if one is necessary.)

Issue 2:

> What are the necessary components of a high-quality election model?

At a future meeting, Council will be asked should the current election model remain as is, be amended or replaced. To answer that question, Council will have to determine the necessary components of a high-quality election model.

To aid the discussion, examples of 5 models are provided.

Current election model: Focuses on geographical representation. Theoretically, this should bring a diversity of regional experiences and stakeholder perspectives to Council.

Is this model sufficient or does it create potential weaknesses for future Councils having sufficiently skilled and qualified members? What are the pros and cons of this model?

Area of Practice Model: The 8 positions on Council would be assigned to represent the various areas of practice. For example: Family, surgeons, specialists.

Note: Associate Registrants are represented under this model. Registrants who are educators are represented by the selection from the Faculty of Medicine.

What are the pros and cons of this model?

Business Model Type of Practice: The 8 positions on Council would be assigned to represent the various means by which registrants carry out the practice of medicine. For example, private clinics

and institutional settings. These categories can be further subdivided to reflect urban and rural practice settings or some other descriptor.

What are the pros and cons of this model?

Demographic Composition: The 8 positions on Council would be assigned to model the demographics of the registrant population. For example, the 8 positions would reflect the gender, age, race, IMG/CDN Medical Graduates, areas of practice of CPSM registrants.

What are the pros and cons of this model?

Competency/Characteristics/Skills Based: This option can be presented in numerous ways. However, the essential concepts are that "qualifications" are identified as desired requirements for Council and members are elected based upon those "qualifications".

What are the pros and cons of this model?

Secondary Logistical Considerations for these options:

All 5 options have secondary logistical considerations for determining candidate eligibility and who can vote for those members. For example, the current model requires a determination that the candidate has a practice within the geographic region and only those registrants who practice in the region can vote for the candidate.

The Competency/Characteristics/Skills Based option would require a body to assess whether potential candidates have the requisite requirements. This option could, depending upon what are the appropriate competency/characteristics/skills, incorporate elements of the other 4 options.

Who can vote for whom will have to be determined. For example, if composition is to be based upon areas of practice do only registrants in that area of practice get to vote for that seat or would all members have 8 votes, one for each seat?

What are other issues related to setting candidacy requirements and voting eligibility?

DEI Considerations:

The reason for having diversity on Council is to bring a diversity of thought, perspectives, and experience to table. It is important that this requirement is understood. It must not be a check the box exercise. Just because a person is "x" does not mean that they have thoughts,

perspectives, and experiences of person typically associated with being "x". Personal experience may have a greater impact on them than being "x".

If DEI is a requirement for Council composition who determines if a candidate has the diversity requirement and who votes for those persons?

***Public Interest/Representation*:**

Most of the options include components representing the diversity of the profession, whether it be the diversity of areas of practice or demographic considerations. However, the purpose of the CPSM is the protection of the public. It is assumed having the diversity of the profession represented better supports the overall protection of the public.

An absurd example to illustrate the point: if the bylaws were set so that the elected 8 positions could only be psychiatrists practicing in private clinics in Tuxedo; decisions they make, even if they all had excellent qualifications, would not be based upon a diverse breadth of knowledge and experience. The public would not be well protected by this narrow diversity.

That said, the diversity of the profession does not reflect the diversity of the general population. Having public representative appointees helps address represent the diversity of the general population; it also enables filling skill set gaps necessary for proper functioning of Council – accounting/auditing/legal skill sets that are unlikely to be held by any physician. Therefore, it is important for a skills matrix/inventory to be established which can be used by Council and government when considering making public representative appointments.

How important is it for registrants on Council to also reflect the diversity of the general population?

Indigenous Physicians:

The Indigenous population of Manitoba is slightly less than 20% of the overall population. Having 20% Indigenous representation on Council would be 3.6 Councillors (3 or 4). Indigenous physicians do not make up 20% of CPSM registrants. Having 3 or 4 Indigenous Councillors can be maintained through public representative appointees and elected Indigenous physicians.

Is having an Indigenous physician on Council necessary? Should there be a designated Indigenous physician position (above DEI comments are applicable) or can this be achieved by some other means?

Other issues missed

What are other relevant issues and factors that CPSM should be considering?

CPSO

BOARD PROFILE

Behavioural Competencies, Unique Skills and Experiences, and Diversity Attributes Descriptions

Behavioural Competencies	Unique Skills & Experience	Diversity Attributes
Focus on the Public Interest Understanding of and commitment to CPSO's public interest mandate; ability to put interests of the public ahead of other interests, including one's own	**Governance** Demonstrated knowledge and understanding of good governance principles and practices, possibly gained through board experience or governance education or certification	**Patient Population(s) Served** Experience gained through providing direct care to patients from diverse populations and through diverse healthcare settings, which could include but not be limited to serving equity-seeking groups facing discrimination; for further examples, reference our Equity, Diversity and Inclusion page
Commitment & Preparedness Able to meet expectations and commitment required of all board members; comes well prepared to engage in discussion and debate	**Health System Knowledge** Understanding of the health care system in Ontario and the respective roles and responsibilities of key stakeholders including government and other health organizations. Familiarity with historical and current trends in health services delivery, access to care and health outcomes	**Practice Location** Diverse perspectives and experiences will be brought to the board from practitioners who practice across urban, rural, remote and/or underserviced areas of Ontario
Ethics & Integrity Is honest and has strong moral and ethical principles and values	**Risk Oversight** Good understanding of the board's role and responsibility for identifying and reviewing risks, and overseeing the management of identified risks	**Practice Type** Diverse perspectives and experiences will be brought to the board from practitioners who practice in different practice settings
Communication Skills Listens with intent for most effective engagement with others; communicates and responds in manner that demonstrates sensitivity and acceptance of diverse views	**Knowledge of Professional and Occupational Regulation** Good understanding of the role and purpose of a health regulatory College in Ontario and how professions, and the medical profession in particular, are regulated	**Education Profile** Diversity in when and where one graduated and in what special area(s)
Respectful, Self-aware & Courteous Is respectful and courteous; demonstrates insight and awareness into one's own capabilities and strengths, and uses an emotional intelligence approach in particularly difficult or challenging matters	**Leadership** Demonstrated experience leading teams and/or organizations; ability to lead, inspire and provide feedback and direction to others	
Critical & Strategic Thinker Able to identify the primary issue under consideration and evaluate different approaches, solutions and possible consequences before rendering an opinion; can recognize wider issues facing the College and the Board and consider the implications of decisions on the organization's strategic or long-term goals	**Financial Literacy & Experience** Able to understand conceptually the financial position of CPSO as presented in the financial statements and generally accepted accounting principles; can read, interpret and ask questions about financial statements and reports	
Open-Minded & Flexible Remains open to all ideas and is willing to change a position if presented with new evidence or information that supports a change	**Lived Experiences contributing to EDI** Demonstrated or lived experience in issues related to equity, diversity, and inclusion, possibly gained through living, serving or working with diverse or marginalized populations	

COUNCIL MEETING - MARCH 19, 2025

FOR INFORMATION BRIEFING NOTE

SUBJECT: **Rady Faculty of Health Sciences Strategic Plan 2024-29**

BACKGROUND:

Councillor Dr. Peter Nickerson, Vice-Provost (Health Sciences) & Dean, Rady Faculty of Health Sciences will present the attached ***Appendix A, B and C:***

> *MOMENT**UM** Leading Change Together – University of Manitoba & Rady Faculty of Health Sciences Strategic Frameworks, Max Rady College of Medicine Strategic Action Plans*

University of Manitoba

CPSM
18 March 2025

MOMENTUM

Leading Change Together

University of Manitoba & Rady Faculty of Health Sciences Strategic Frameworks

Max Rady College of Medicine Strategic Action Plans

University of Manitoba

The University of Manitoba campuses are located on original lands of Anishinaabeg, Ininewuk, Anisininewuk, Dakota, Dene and Inuit, and on the National Homeland of the Red River Métis.

We respect the Treaties that were made on these territories, acknowledge the harms and mistakes of the past and present.

We dedicate ourselves to move forward in partnership with Indigenous communities in a spirit of Reconciliation and collaboration.

Vision

The University of Manitoba will be a vibrant and thriving community, enriched by Indigenous knowledges and perspectives. We will lead change for a better Manitoba and world.

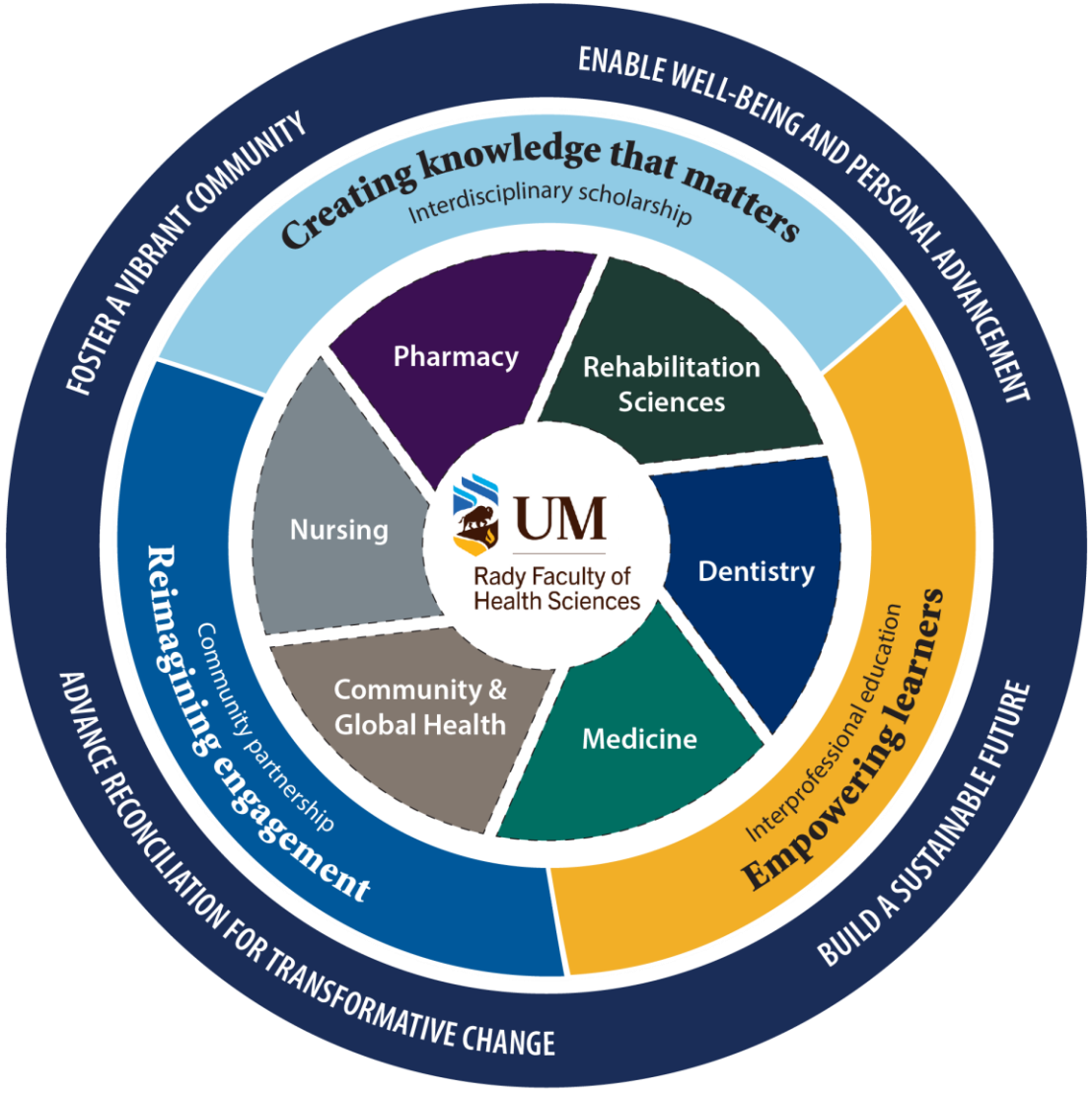
Mission

We advance learning by creating, sharing, preserving, and applying knowledge in partnership with diverse communities to promote the cultural, social, and economic well-being and health of Manitoba, Canada, and the world.

Rady Faculty of Health Sciences

Mandate

*To advance **excellence** in collaborative health care through innovative, socially accountable & just scholarship, education and service, improving the health of people and communities*



Manitoba's Health System

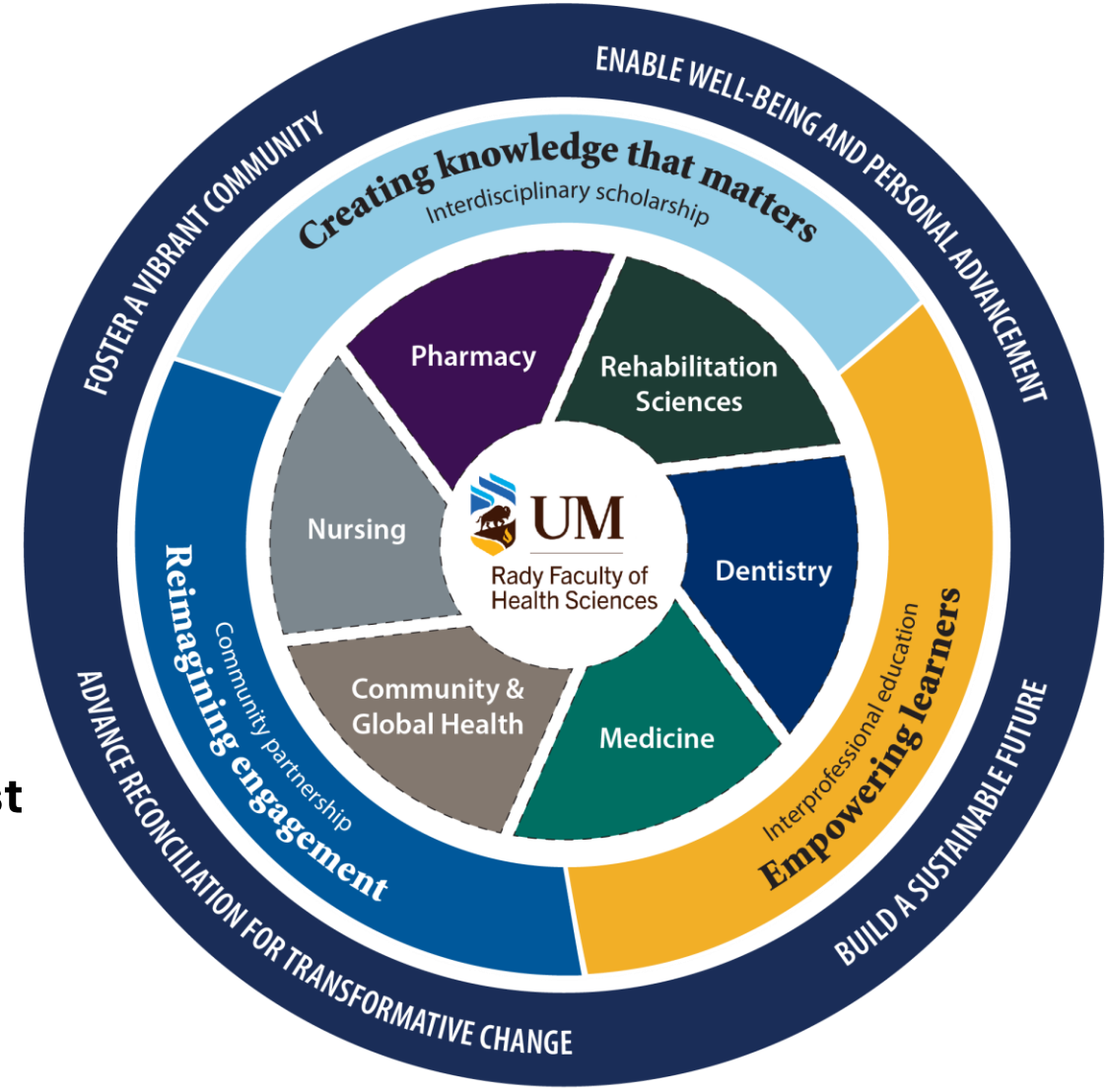
- Not designed with people at the center
- Not optimized to deliver efficiencies
- Not focused to learn and implement knowledge

Result is front line services characterized by:

- People without a primary care provider
- Lack of health professionals in rural/remote communities
- Long wait-times to access primary and specialty care
- Inability to access cutting-edge standard of care

How can the UM Rady Faculty of Health Sciences best

- ✓ Serve Manitobans,
- ✓ Provide solutions to wicked problems, and
- ✓ Be accountable for publicly invested resources?

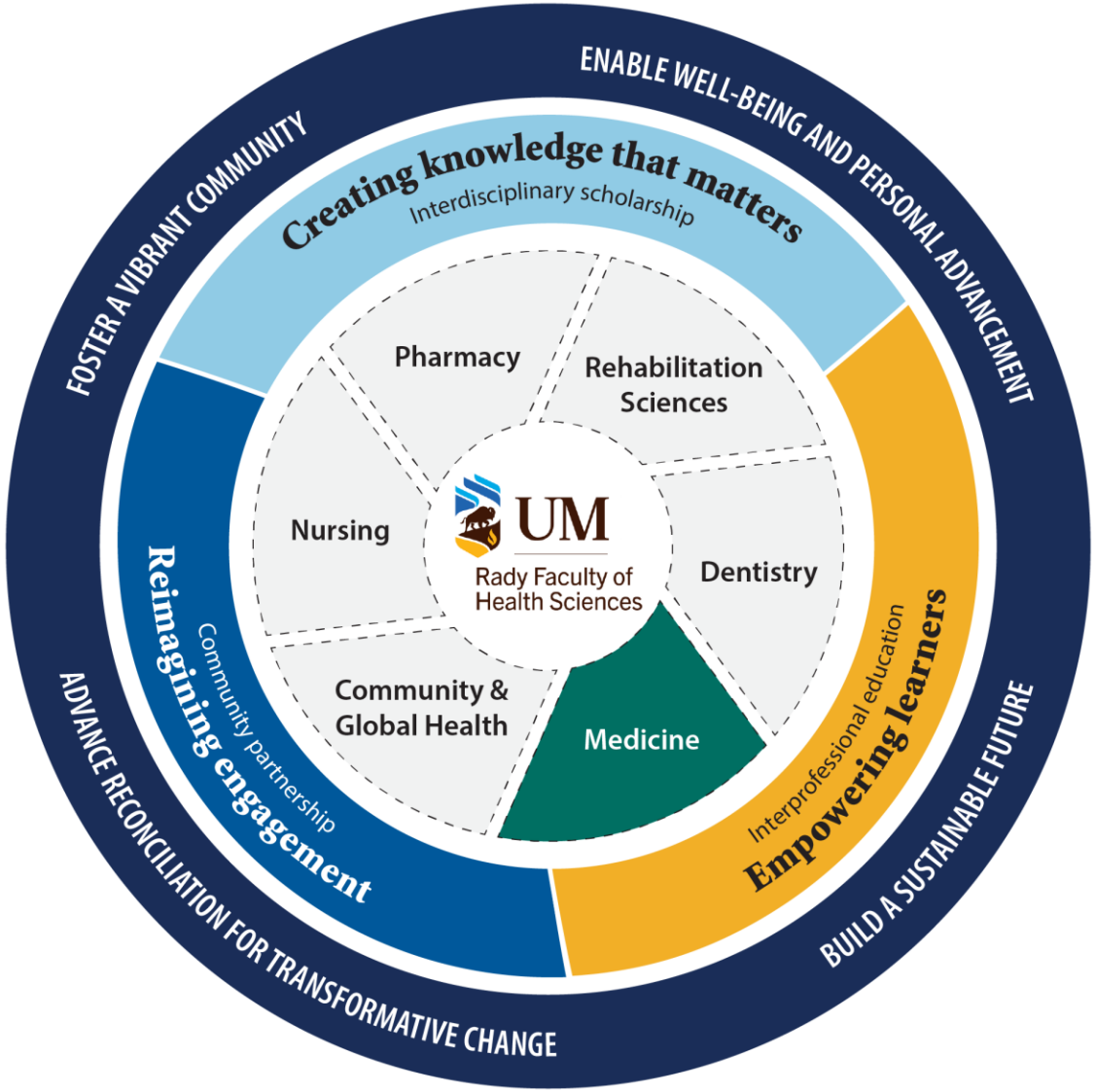


Model of Excellence

- We meet the health needs of individuals and communities in Manitoba and beyond
- We deliver high quality health professional and graduate education
- We value, embed, and advance scholarship and innovation in our programs
- We foster safe environments where learners, staff, and faculty are healthy and fulfilled
- We insist on continuous quality improvement in our programs

Lens through which decisions are made and resourced to deliver

Superior Results **Distinctive Impact** **Lasting Endurance**



Critical Appraisal of Current State
Sep-Dec 2022

Brand:

- **Who people say we are**
- **How we want to be seen**

Manitoba

- Friendly and collaborative
- Value and celebrate multicultural communities
- Affordable housing and cost of living
- Vibrant art, sport and culture scenes
- **Small enough to connect & network, large enough to have impact**

Max Rady College of Medicine (MRCoM)

- Ambitious to do/be better; Challenge the status quo
- Research intensive faculty driving discovery with impact
- Quality graduate education built on fdn of cutting-edge science
- Valued partnership with the Health System and Government
  - ✓ **Align strategy/investment on solution focused goals**
  - ✓ **Foster a Learning Health System**
- Advance environments where national/international leaders emerge
- Promote mentorship and career advancement
- Committed to equity, access and participation
- Create safe space to hear concerns
- **Physicians connected with MRCoM throughout their career**

Pre-Admission/Admissions

- Support **Indigenous communities and learners** to access programs
- Transparent/Accountable admission processes

UGME **Fully accredited program (unique in Canada) – next cycle 2027**

- **High quality spiral curriculum informed by student feedback**
- Small group learning fostering outstanding clinical reasoning
- High level of support for students (e.g., Student Affairs, financial)

PGME

- **Prioritize Manitoba UGME grads in PGME programs** & welcome others
- **Unique IMG training pathways to practice** leveraging PGME programs

MPAS/UGME/PGME/IMG

- Experiential learning is high quality
  - ✓ **Independence of learning environment**
  - ✓ **Scope of exposure as the lead person**
  - ✓ **Set high expectation – responsible active team member**
- Exposed to a full breadth of medical case mix
- **Prioritize opportunities for distributive education**

MPAS & MSc. Genetic Counselling

- High quality programs attracting students from across Canada

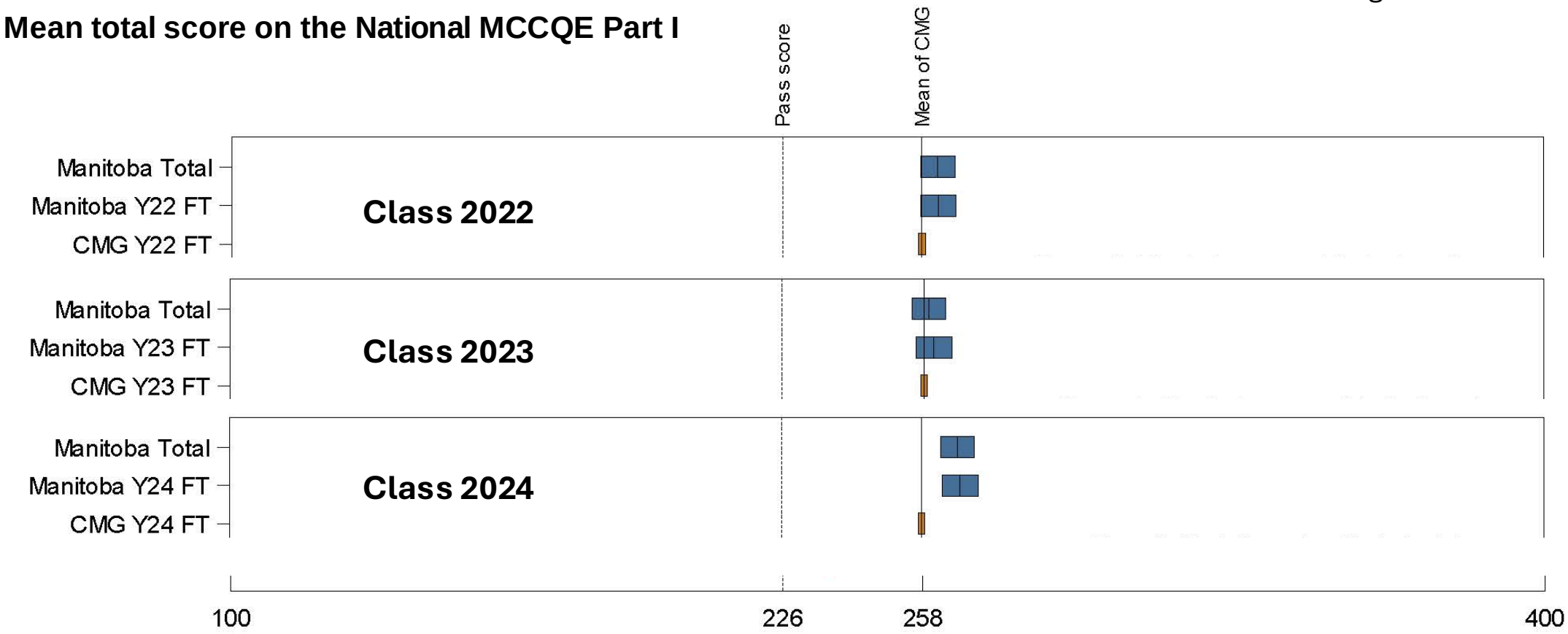
CPD/CCA

- Support physicians acquire and demonstrate their maximum abilities

Medical Doctor Program

Pass Rate

- 98-100% University of Manitoba
- 94% National Average



Note – Total is all grads in the year; FT is grads who are first time taking the exam in the year

Confront the Brutal Facts (Fall 2022)

Medical Education Overarching Issues
- Onboarding and professional development of faculty and staff sub-optimal
- Tenuous trust between learners and faculty inhibiting constructive feedback
- **Clinical preceptor capacity rate limiting for sustainable program expansion**
- **Infrastructure insufficient to support program expansion**
- Remuneration not standardized for physician faculty across/in departments

Admissions **Principle – graduates should reflect the communities we serve**
- Insufficient training seats available [**110 seats (78/mil pop); >800 applicants**]
- **Low # of Indigenous students prepared to enter medicine**

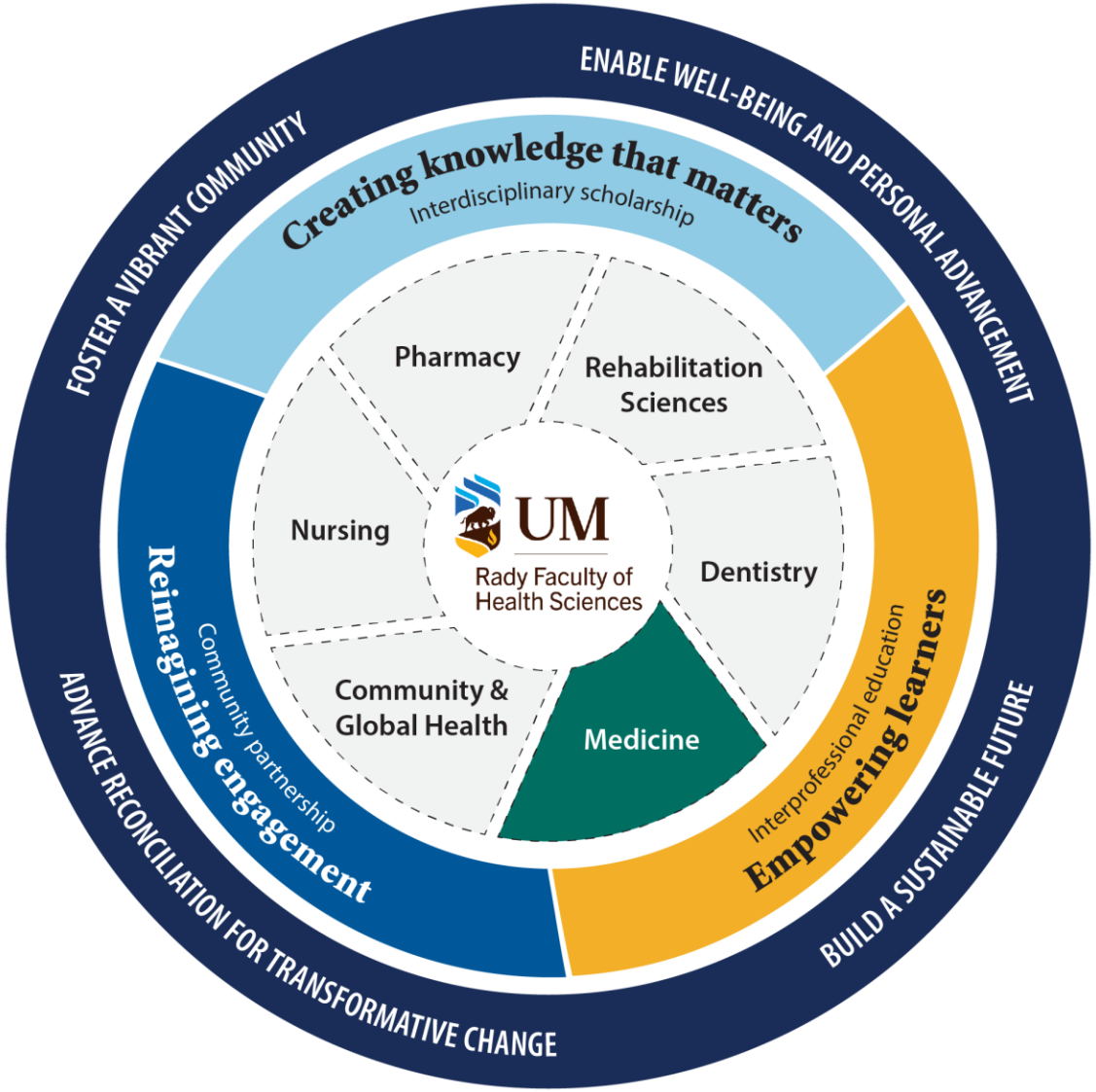
UGME
- **Lack of generalist role models in Med 1 and Med 2**
- **Lack of standardized small group longitudinal learning in Med 1 and Med 2**
- Curriculum refresh required to address gaps and advances in medical education
- Gaps in student supports (e.g., bursaries, funding for distributive education)

PGME **Major gaps identified in 2022 accreditation – critical review in 2024/25**
- Key programs not optimized to meet all accreditation requirements
- **Lack of detailed workforce needs assessment**
- Recruitment of PGME graduates sub-optimal [**71% Generalist; 50% Specialists**]
- Assessment and training of International Medical Graduates (IMG) is sub-optimal

Clinical/Biomedical Graduate Education & Research Programs
- Research potential not fully realized
- **Graduate student stipends not standardized nor optimized**
- Need to enhance interdisciplinary education and research
- **Lack of funding mechanisms for Clinician-Investigators**
- Limited support and incentives for commercialization of novel discoveries/knowledge – **lost economic opportunity for MB**
- Core facilities require scope optimization and updating
- High administrative burden & barriers to basic/clinical research
- **Lack of health system prioritization of research** as a foundational part of creating a "**Learning Health System**"

Master of Physician Assistant Program (MPAS)
- Sub-optimal training seat numbers given workforce demand
- **Financial burden excessive for students relative to UGME**
- Access to experiential training sites in competition with others

Master Science in Genetic Counselling
- **Financial burden excessive for students relative to UGME**
- Number of faculty & placements limited to deliver the program



Immediate Action Plan 2023/24 to 2024/25

Model of Excellence

We meet the **health needs of individuals and communities in Manitoba** and beyond

Focus

- **Primary Care** (especially rural/northern)
- **Mental Health Services**
- **General Specialty Services**

			Expansion 2023/2024	Expansion 2024/2025	Expansion 2025/2026	Total Increase / Year	Baseline Annual Intake 22/23	Final Target Total / Year
UGME		4yr	**15**	**15**		**30**	**110**	**140**
PGME	Family Medicine (**IMG**/CMG)	2yr	**10**	**10**	**10**	**30**	**52**	**82**
	Clinical Health Psychology	1yr		**2**	**3**	**5**	**12**	**17**
	Psychiatry	5yr	**1**	**2**	**2**	**5**	**12**	**17**
	General Specialty	5yr	**5**	**5**	**5**	**15**	**79**	**94**
International Medical Graduate (IMG)		1yr	**5**	**5**		**10**	**20**	**30**
Master of Physician Assistant Program		2yr		**15**		**15**	**15**	**30**

Brandon Satellite Campus Proposal

2023-2026

Phase I

Building Clinical Instructor Capacity

- Lack of physician educators

Solution

- ↑ PGME Family Medicine training
- ↑ Recruitment of Family Medicine

- **Current Clerkship (yr 3) 5/yr**

2026-2028

Phase II

Building Clinical Training Capacity

- Lack of clinical education space

Solution

- Brandon Hospital Expansion
- Build clinical teaching space

- **Expand Clerkship (yrs 3&4) 16/yr**

2028-2030

Phase III

Building Pre-Clinical Training Capacity

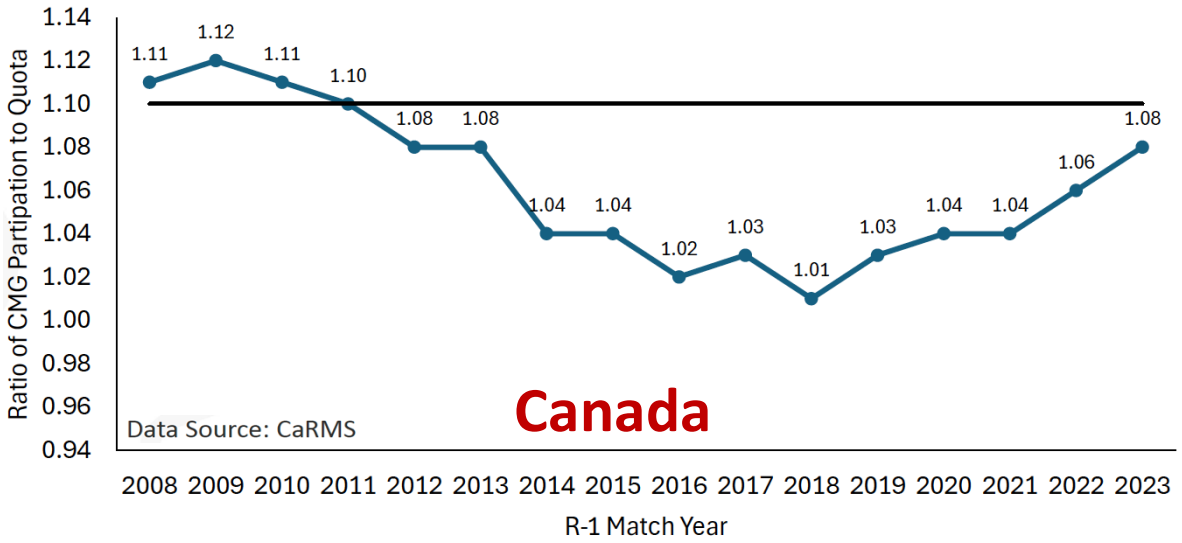
- Lack of classroom/simulation space

Solution

- Build UM Satellite Facility

- **Launch Pre-clerkship (yrs 1&2) 16/yr**

PGME Program Recruitment Opportunity



Year	UGME	PGME	Ratio
2010-22	110	143	1.30
2023	110	159	**1.45**
2024	110	174	**1.58**
2025	110	190	**1.72**
2026	110	190	**1.72**
2027	125	190	**1.52**
2028	140	190	1.36

Manitoba's Opportunity

↑ IMG
↑ CMG

Strategic Action:

- Marketing to Manitoban CMGs & IMGs in UK/Ireland/Australia/US
- Develop Provincial Workforce Plan to assign PGME training seat priorities

Post-training retention in MB is critical (Sustainable Solution)

Max Rady College of Medicine

University of Manitoba

Empowering Learners
Creating Knowledge that Matters

PGME 2022 Accreditation Report

Royal College of Physicians and Surgeons of Canada
College of Family Physicians of Canada

Full Accreditation Regular Review in 2030

- **31 Programs**

Action Plan Outcomes Report (APOR) in 2024

- **Max Rady College of Medicine PGME Program Office**
- General Internal Medicine
- Medical Genetics and Genomics
- Nephrology (Adult)
- Pediatrics
- Neonatal-Perinatal Medicine
- Gynecologic Oncology
- Surgical Foundations
- Otolaryngology (Head & Neck Surgery)

External Review in 2024

2024 Review

- **Cardiology** (Adult) → **APOR**
- **Radiation Oncology** → **Regular Review**
- **Nuclear Medicine** → **Closed by PGME**

2025 Review

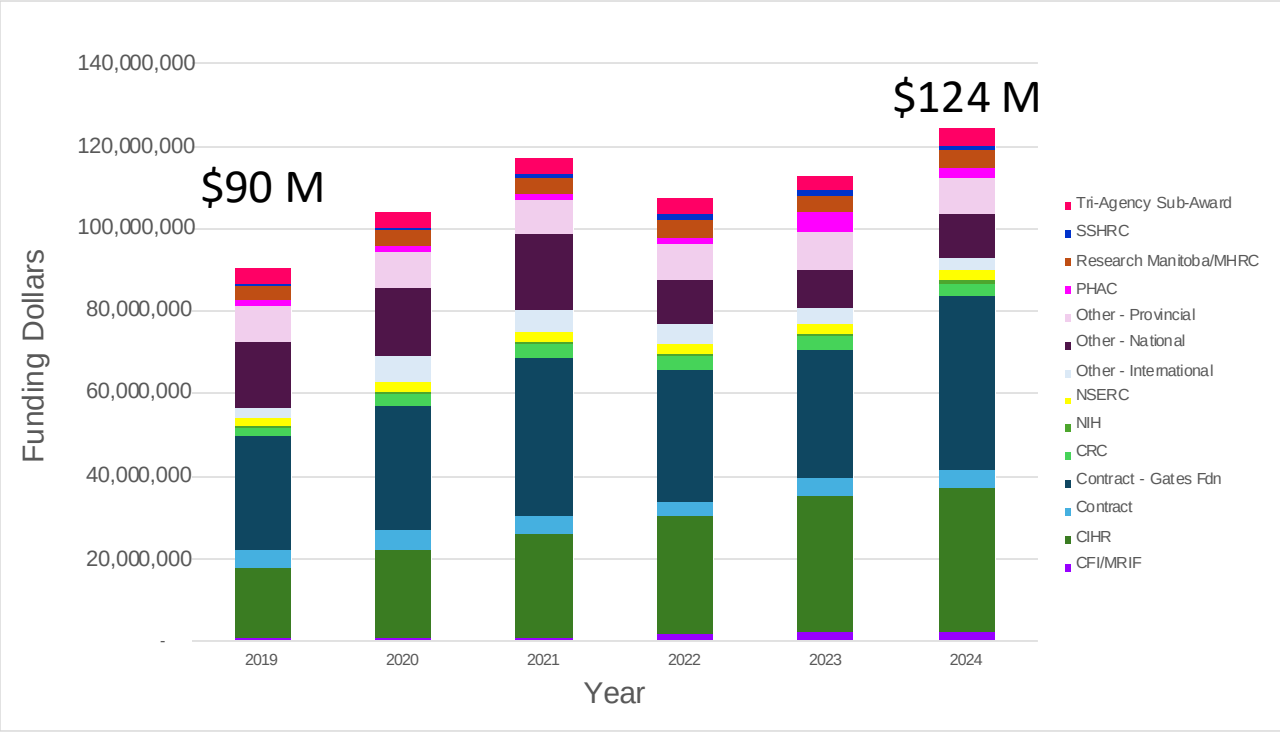
- **Family Medicine** – Core
- **Family Medicine** – Skills

Intent to Withdraw Accreditation in 2024

2024 Review

- **Internal Medicine** – Core → **APOR**
- **Obstetrics & Gynecology** → **APOR (LPI)**
- **Neurology** (Adult) → **APOR**

Annual Research Funding by Agency 2019 to 2024



Federal Funding $51,081,177 (↑$23M$_{2019}$)

Gates Foundation $41,936,777 (↑$14M$_{2019}$)

Research Manitoba $ 4,232,777 (↓$ 2M$_{2017}$)

Funding Group	2019	2020	2021	2022	2023	2024
CFI/MRIF	518,457	549,478	877,203	1,642,091	1,931,417	2,206,266
CIHR	17,146,487	21,493,110	24,906,726	28,370,892	33,252,545	35,012,976
Contract	4,281,592	5,020,104	4,525,173	3,609,354	4,033,697	4,179,958
Contract - Gates Fdn	27,483,190	29,949,021	38,246,385	31,961,688	31,053,495	41,936,777
CRC	2,511,195	3,059,810	3,430,274	3,503,728	3,387,612	3,175,100
NIH	209,312	131,592	243,294	247,396	624,560	624,560
NSERC	1,994,274	2,337,221	2,578,660	2,542,523	2,508,648	2,832,870
Other - International	2,242,028	6,640,212	5,361,188	4,652,421	3,687,221	2,893,865
Other - National	16,067,620	16,444,592	18,096,578	10,758,196	9,430,122	10,308,119
Other - Provincial	8,463,845	8,494,468	8,497,756	8,879,165	9,188,145	8,830,500
PHAC	1,494,887	1,322,257	1,395,784	1,477,085	4,602,840	2,524,897
Research Manitoba/MHRC	3,367,623	3,941,982	3,908,332	4,284,480	4,213,122	4,232,777
SSHRC	609,192	763,015	895,614	1,157,491	1,011,505	944,180
Tri-Agency Sub-Award	3,677,096	3,697,067	4,102,981	3,908,495	3,522,623	4,384,888
Grand Total	90,066,797	103,843,930	117,065,949	106,995,004	112,447,551	124,087,735

Target $200,000,000 by 2030

Model of Excellence

We deliver high quality **medical** professional and **graduate education**

We value, embed, and advance **scholarship and innovation** in our programs

Immediate Action Plan 2023/24 to 2024/25

College of Community and Global Health – Finish standing up independent from College of Medicine

- Transform the **Bachelor of Health Studies** → **Bachelor of Community Health Sciences** assigned to the College
- Advance expertise in Social Determinants of Health, Social Justice & Health, Health Policy & Administration, and Data Science
- Work in reciprocal partnership with **Indigenous governments/communities**, and organizations serving other health equity deserving populations (e.g., Black, racialized, newcomers, 2SLGBTQIA+, socially and structurally disadvantaged groups)

School of Biomedical Sciences – Develop a proposal to establish inside the College of Medicine

- Aggregate the biomedical science departments under the umbrella of a Director and School Council
- Expand the **Bachelor of Health Sciences** from **40** → **100 seats**/yr and embed it as a foundational degree program for the School
- Potential for a MSc/PhD in Health Sciences as a pathway to train clinician-investigators focused on translational science

Dean, Max Rady College of Medicine

- Academic
  - Assoc Dean Academic
- Professionalism
  - Assoc Dean Professionalism
- Research
  - Assoc Dean Research
- Medical Education
  - Assoc Dean Accreditation
  - Assoc Dean Student Affairs
  - Assoc Dean Admissions
  - Assoc Dean UGME
  - Assoc Dean PGME
  - Assoc Dean Brandon Site
  - Assoc Dean CCA
- School of Biomedical Sciences
  - **School Director**
    - Dept Head Human Anatomy & Cell Science
    - Dept Head Biochemistry & Medical Genetics
    - Dept Head Physiology & Pathophysiology
    - Dept Head Pharmacology & Therapeutics
    - Dept Head Medical Microbiology & Infectious Disease
    - Dept Head Immunology
    - Bachelor of Health Sciences Program
- Clinical Department Heads & Provincial Specialty Leads
  - Canadian Psychological Association Accreditation
    - Dept Head Clinical Health Psychology
  - College of Family Physicians of Canada Accreditation
    - Dept Head, Family Medicine
      - International Medical Graduates Program
      - Master of Physician Assistant Program
  - Royal College of Physicians and Surgeons of Canada Accreditation
    - Dept Head Surgery
    - Dept Head Internal Medicine
    - Dept Head Pediatrics & Child Health
    - Dept Head Psychiatry
    - Dept Head OB/GYN & Reproductive Sciences
    - Dept Head Anesthesia
    - Dept Head Pathology
    - Dept Head Radiology
    - Dept Head Emergency Medicine
    - Dept Head Otolaryngology
    - Dept Head Ophthalmology

Co-led by **Provincial CMO**

University of Manitoba

Max Rady College of Medicine

Potential MRCoM Career Pathways

U15	BHSc. or BMSc.
U. Calgary	112
U. Alberta	New 250
Dalhousie	120 -> 200
McMaster	229
Queens	440
Waterloo	200
Western	1061

Bachelor of Health Sciences
40/yr (Goal ↑ to 100/yr)

- 4 – year program
- Target **18%+ Indigenous**
- Direct Entry – 70%
- Advanced Entry – 30%
- Applications **>500/yr**

Graduate Studies → **Industry, Health Care, Government**

Post-Doctoral Fellowships → **Academic MSc, PhD**
Industry MSc, PhD
Clinical Lab MSc, PhD

Master Science Genetic Counselling → **Genetic Counselling Health Care Professional**

Rady Colleges (OT, PT, Nursing, MPH) or **Direct to health-related career**

Master of Physician Assistant Studies → **Physician Assistant Health Care Professional**

Under-Graduate Medical Education → **Post-Graduate Medical Education** → **Primary Care MD**
Specialty MD

Model of Excellence

We foster **safe environments** where **learners, faculty and staff** are **healthy and fulfilled**

Immediate Action Plan 2023/24 to 2024/25

- Ongomiizwin – Indigenous Institute of Health and Healing
  - ✓ Expanded wrap around program of learner support with Elders and Indigenous mentors
  - ✓ New Indigenous Cultural Safety Training program – ***We Will Take Good Care of the People***
- Mentorship Program – serving Black, disabled, Jewish, Filipino, Muslim, 2SLGBTQIA+ learners
- Formal curriculum for students
- Formal seminars for faculty and staff

  } on anti-racism and hate speech in social media
- Recruitment of Director of Professionalism for Rady Faculty of Health Sciences
  - ✓ Developing Professional Unsuitability Bylaw in all our professional colleges
- ISME Office: Onboarding faculty, staff and students regarding critical conversations, constructive feedback

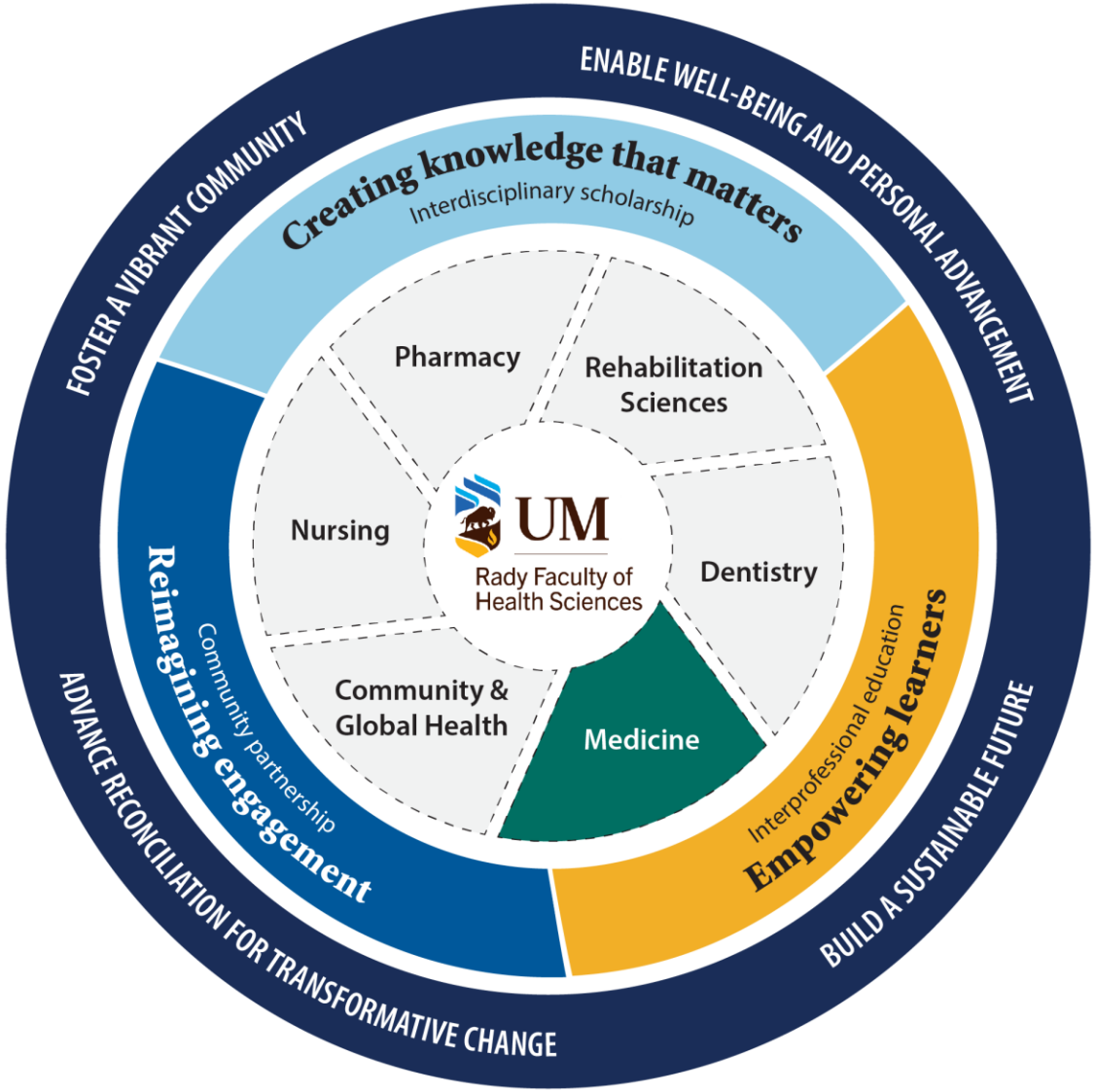
Bannatyne Campus Renewal (2024-2027)

Ongomiizwin – Indigenous Institute of Health and Healing

Dental Clinic – undergraduate & graduate, and dental hygiene training

UGME – lecture theatres, classrooms, and simulation centre

Pre-School/Day Care – support students, staff, and faculty



Strategic Action Plan 2025-2029

Empowering Learners – Interprofessional Education (IPE)

Focus on high quality in all educational programs, meeting the needs of the provincial health workforce

- Ensure onboarding of new faculty to acquire skills and understand the standards required in educational programs.
- Enhance utilization of ISME & CATL offices across educational programs for CQI of curriculum.
- Partner with Provincial CMO to forecast health system workforce needs to align program resource investment.

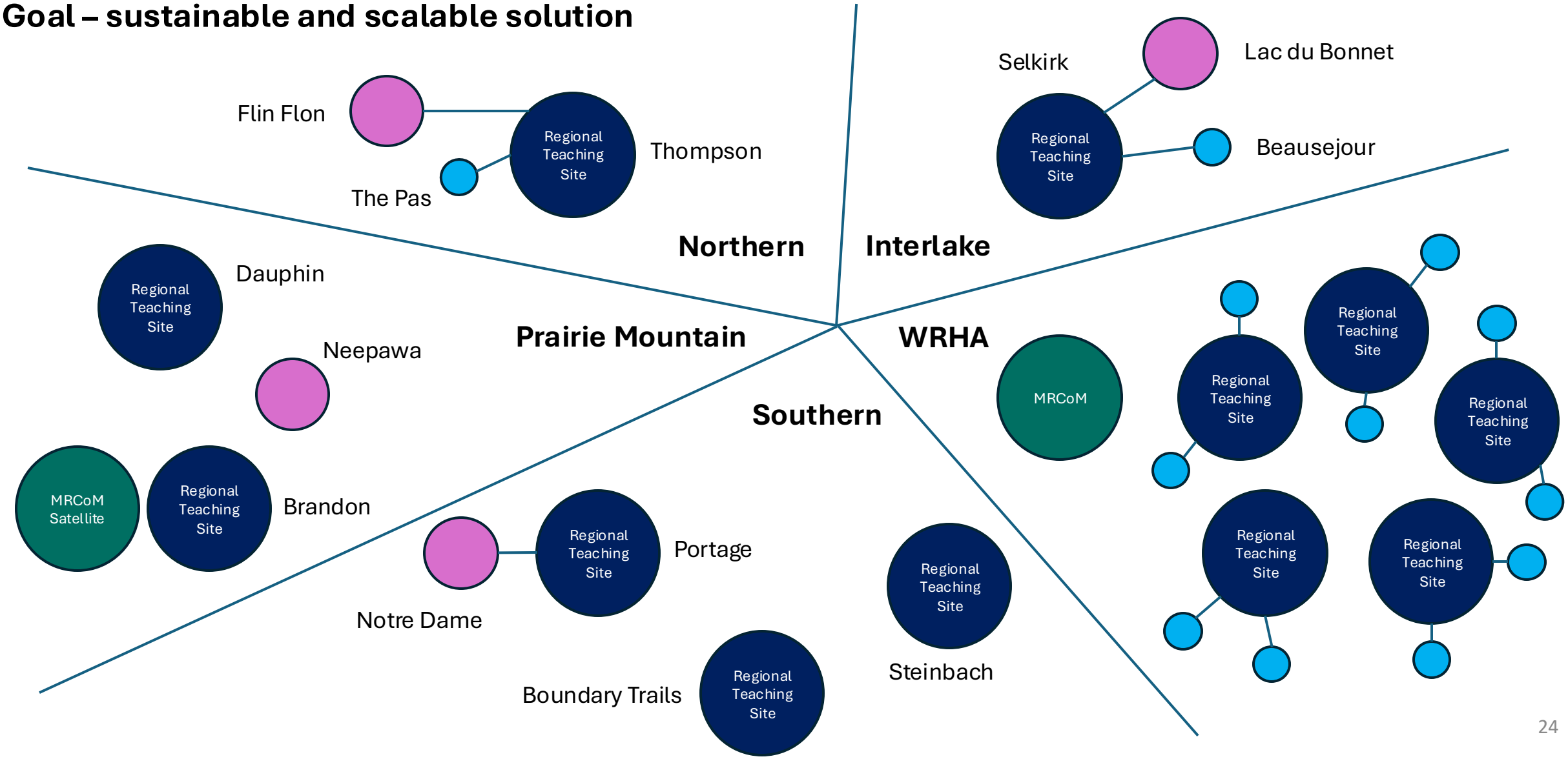
Advance distributive models of education reaching rural, northern and remote communities

- Establish a scalable distributive faculty model (network) for integrated medical education (UGME/PGME/IMG/MPAS).
- Create a sustainable funding mechanism and coordinating office to support student travel and housing.
- Develop and enact a plan to stand up a comprehensive Brandon Satellite Campus for UGME and PGME training.

Expand sustainable and cohesive interprofessional education and clinical opportunities

- Create and refine IPE curriculum for asynchronous and synchronous learning.
- Identify and utilize existing team-based clinics in Med 1 and Med 2 for IPE observational reporting.
- Create IPE hubs that are resourced to support Med 3 and 4 experiential IPE learning.

Goal – sustainable and scalable solution



Creating Knowledge that Matters – Interdisciplinary Scholarship

Increase interdisciplinary and collaborative scholarship that is highly competitive and impactful

- Advance team-based science (i.e., funding and recognition programs, strategic recruitment and networking).
- Establish Clinician-Investigator minimal income base to support protected time (i.e., 75%) to drive innovation.
- Create pathways for knowledge implementation (i.e., health system, clinical practice, and commercialization).

Advance health system and person-centered research, informed by authentic reciprocal engagement

- Increase health system leaders, community leaders, or vested public on research teams as appropriate.
- Increase utilization of "**Learning Health System**" platforms (e.g., CHI, MCHP, Ongomiizwin, and IGPH) by health system leaders, health investigators, and communities to address unmet needs.
- Remove health system barriers and reduce administrative burden to conducting person-centered research.

Enhance core platforms that advance all research pillars (i.e., NSERC/CIHR I, II, III, IV)

- Promote core platform services across the research ecosystem.
- Invest in sustainability of core platforms (i.e., CFI + Provincial match funding).
- Client survey to assess core platform gaps to be addressed to sustain the research ecosystem.

Reimagining Engagement – Community Partnership

Advance and contribute to health system partnerships, informing policy and practice

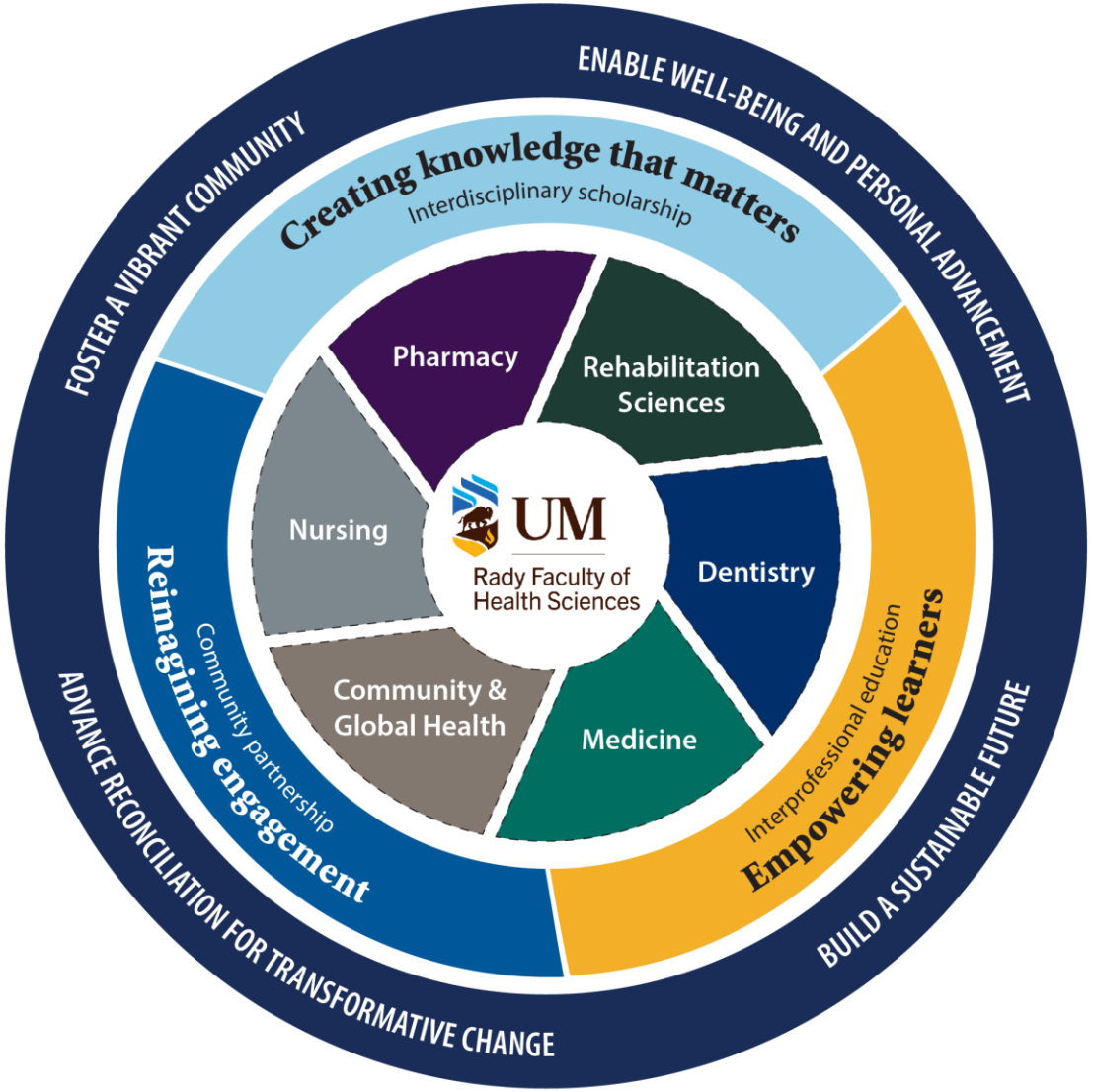
- Establish a clinical governance structure to enable integration of health system & academic clinical programs.
- Involve government and health system leaders on pertinent committees in the MRCoM and Rady FHS.
- Consolidate the framework and support for a sustainable "**Learning Health System**" across Manitoba.

Improve reciprocal community engagement through new and existing outreach programs

- Identify communities that are a priority for engagement.
- Create a formal framework for community engagement with input from and agreement by community.
- Determine community needs and opportunities for partnership.

Increase efforts to support, coordinate and expand pathway programs

- Leverage Bachelor of Health Sciences/Studies programs as pathways to MRCoM programs (focus: Indigenous learners).
- Partner with School Boards for early exposure and support education programs for junior and senior high learners.
- Elevate community awareness and support for educational opportunities in the MRCoM.



Rady Colleges

- Consolidating Immediate Action Plans 2023-24
- Developing Strategic Action Plans 2025-29
- Senior Leadership – significant change in 2025
  - **Dean of Nursing** – February
  - **Dean of Community & Global Health** – active search – April
  - **Dean of Pharmacy** – active search – April to September

(**Dean CoRS** – 2026; **Dean RFHS** & **Dean MRCoM** – 2027)

Rady Faculty of Health Sciences

- Align to University of Manitoba Strategic Framework
- Integrate Strategic Action Plans across Colleges
- Standardize practices across Colleges
- Fostering a **Learning Health System**

The University of Manitoba is committed to:

- Serve Manitobans,
- Provide solutions to wicked problems, and
- Be accountable for publicly invested resources

MOMENTUM:

Leading Change Together

Rady Faculty of Health Sciences

STRATEGIC PLAN 2024-2029

University of Manitoba | Rady Faculty of Health Sciences

MESSAGE FROM THE DEAN

Starting in the fall of 2022, the Rady Faculty undertook a significant consultation process to review and refresh the Rady Faculty strategic plan. Stakeholders were invited to engage in different ways to provide input: through anonymous surveys, focus groups, one-on-one interviews, town halls, and larger planning sessions. These contributions were vital to creating an effective and operational strategic plan that focuses our efforts and actions now and in the coming years to achieve key faculty strategic priorities.

Aligned to the University of Manitoba strategic plan entitled **MOMENTUM: Leading Change Together,** the Rady Faculty strategic plan was endorsed by the Rady Faculty Council in June 2024. Central to this alignment the Rady Faculty and its constituent Colleges agreed to adopt the mission, vision, core values, as well as the strategic themes and the fundamental commitments of the University of Manitoba strategic plan.

Unique to the Rady Faculty strategic plan was the development of a mandate for the Rady Faculty, and while the strategic themes and fundamental commitments aligned to those of the University, the Rady Faculty customized the goals of its strategic plan to reflect this unique mandate. Further the Rady Faculty strategic plan has developed metrics that all Colleges will use to assess annual progress.

Together, we have created a roadmap that defines the Rady Faculty's strategic priorities that will guide us for the next five years (*https://umanitoba.ca/strategic-plan*).

I look forward to working together to advance the Rady Faculty of Health Sciences as an integral member of the broader University of Manitoba community.

Dr. Peter Nickerson
Vice-Provost (Health Sciences) & Dean, Rady Faculty of Health Sciences

TRADITIONAL TERRITORIAL ACKNOWLEDGEMENT

The University of Manitoba campuses are located on original lands of Anishinaabeg, Ininewuk, Anishininewuk, Dakota Oyate, Denesuline and Nehethowuk peoples, and on the National Homeland of the Red River Métis.

UM respects the Treaties that were made on these territories, acknowledges the harms and mistakes of the past and present, and dedicates itself to move forward in partnership with Indigenous communities in a spirit of Reconciliation and collaboration.

UM recognizes that this acknowledgment only holds meaning when reflected in the actions taken to address the injustices and barriers that have disproportionally affected Indigenous Peoples and communities, systemically preventing them from accessing and benefitting from education. Grateful for the territories and lands on which the university community learns, conducts research, and engages with external partners, UM is guided by this acknowledgment in carrying out the core work of its mission, the priorities it sets, and the decisions made to move forward as an institution.

VISION, MISSION, VALUES

The University of Manitoba is Manitoba's research-intensive (medical-doctoral) university, and the Rady Faculty aligns with the Mission, Vision and Values of the University of Manitoba:

VISION

The University of Manitoba will be a vibrant and thriving community, enriched by Indigenous knowledges and perspectives. We will lead change for a better Manitoba and world.

MISSION

We advance learning by creating, sharing, preserving, and applying knowledge in partnership with diverse communities to promote the cultural, social, and economic well-being and health of Manitoba, Canada, and the world.

CORE VALUES

BELONGING

We foster trust, acceptance, and mutual respect, rooted in human rights and dignity of all. We strive to create the conditions for all to be their authentic selves. We change systems and structures that exclude. We empower success through our dedication to Reconciliation, Indigenization, and to a university community that centers equity, accessibility, diversity, and inclusion.

CURIOSITY

We value the pursuit of knowledge and uphold academic freedom. We celebrate curiosity and its essential role in learning, research, scholarly work, and creative activity. We empower the creation and sharing of knowledge in all its forms, including Indigenous knowledges and ways of knowing, to foster deeper understanding, create new connections, and address society's most pressing issues.

IMPACT

We partner to find solutions to societal, cultural, economic, and environmental issues. Through collaboration, inclusivity, empathy, and valuing diverse ways of knowing, we create global citizens. We centre community as we participate in the process of Reconciliation, and contribute to positive and meaningful change in Manitoba, Canada, and the world.

INTEGRITY

We maintain high ethical standards and ensure ethical stewardship. We share a commitment to human dignity, open dialogue, transparency, professionalism, accountability, and collegial governance.

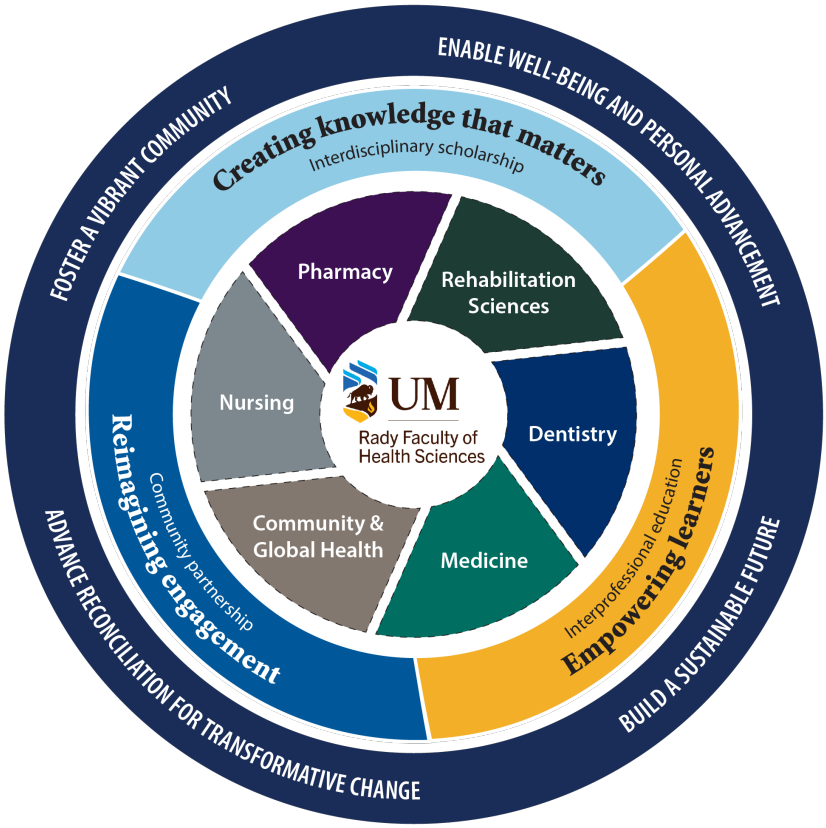
WELL-BEING

We advance the personal and professional growth and academic success of our community members. Grounded in respect and compassion for each other and our community, we cultivate a supportive environment that embraces the values of mino-pimatisiwin (good life) and mino-ayawin (good health).

MANDATE

The Rady Faculty has a distinct role in delivering the University of Manitoba mission and vision related to health education and research. As such the Rady Faculty has developed a faculty-wide mandate, shared across the Rady Faculty and its constituent Colleges:

To advance excellence in collaborative health care through innovative, socially accountable and just scholarship, education, and service, improving the health of people and communities.



To guide this mandate the Rady Faculty has developed a "**Model of Excellence**" as its aspirational brand comprised of the following attributes:

- We meet the health needs of individuals and communities in Manitoba and beyond
- We deliver high quality health professional and graduate education
- We value, embed, and advance scholarship and innovation in our programs
- We foster safe environments where learners, staff, and faculty are healthy and fulfilled
- We insist on continuous quality improvement in our programs

This Model of Excellence is the lens through which strategic decisions will be made and resourced to deliver superior results of distinctive impact that will have a lasting endurance. Indeed, this is the Rady Faculty's commitment and public accountability as it executes the 2024-2029 strategic plan.

STRATEGIC PLAN

The Rady Faculty's strategic themes align with those of the University of Manitoba. We will focus on:

Empowering Learners – Interprofessional Education

- Focus on high quality in all core programs, meeting the needs of the provincial health workforce
- Advance distributive models of education reaching rural, northern and remote communities
- Expand sustainable and cohesive interprofessional education and clinical opportunities

Creating Knowledge that Matters – Interdisciplinary Scholarship

- Increase interdisciplinary and collaborative scholarship that is highly competitive and impactful
- Advance health system and person-centered research, informed by authentic reciprocal engagement
- Enhance core platforms that advance all research pillars (i.e. NSERC/CIHR I, II, III, IV)

Reimagining Engagement – Community Partnership

- Advance and contribute to health system partnerships, informing policy and practice
- Improve reciprocal community engagement through new and existing outreach programs
- Increase efforts to support, coordinate and expand pathway programs

Three fundamental commitments drive the work of the Rady Faculty and span all strategic themes:

Fostering a Vibrant Community

- Ensure common core competencies in social justice, anti-racism, ableism, and anti-oppressive practices for all
- Achieve equity, access, and participation at all levels within the Rady Faculty
- Ensure culturally safe and inclusive work and learning environments that invite participation by everyone

Advancing Reconciliation for Transformative Change

- Implement the revised Rady Reconciliation Action Plan
- Embed Indigenous initiatives and Indigenization of curricula in all programs
- Increase recruitment of, and support for, Indigenous learners that remove barriers

Increasing Wellbeing and Personal Advancement

- Adopt the principles of the Okanagan Charter
- Establish work and learning environments that promote balance and wellness
- Increase and formalize mentorship and professional development opportunities for faculty and staff

In addition, to build a sustainable future, the Rady Faculty will apply a sustainability lens to its actions and operations, through ethical decision-making, continuous improvement, and the integration of sustainable practices in everything the Rady Faculty does.

IMPLEMENTATION

The next stage requires each of the Rady Faculty constituent Colleges to develop a strategic action plan that will deliver on the Rady Faculty strategic plan. These will be companion documents to the overarching Rady Faculty strategic plan.

The Rady Faculty has identified the following measures and indicators to assess progress in implementing the strategic plan.

EMPOWERING LEARNERS – INTERPROFESSIONAL EDUCATION (IPE)

Expand sustainable and cohesive interprofessional education and clinical opportunities	# high-quality IPE environments for modeling team-based practice. % class having a high-quality IPE experience.
Advance distributive models of education reaching rural, northern and remote communities	% learners having a rural/remote education experience during training. % learner satisfaction with rural/remote exposure. % community satisfaction with rural/remote exposure.
Focus on high quality in all core programs, meeting the needs of the provincial health workforce	% programs with accreditation/academic program approvals (track number of citations). Performance on national exams (aggregate score, %pass). % Retained in province in next phase of career.

CREATING KNOWLEDGE THAT MATTERS – INTERDISCIPLINARY SCHOLARSHIP

Increase interdisciplinary and collaborative scholarship that is highly competitive and impactful	# policies, guidelines and/or practice change citing scholarship. # Faculty with tri-agency and other team grant program funding.
Advance health system and person-centered research, informed by authentic reciprocal engagement	# grants that have patient advocate/community reps on research teams. Evaluate/measure community experience in their engagement and its impact (community survey).
Enhance core platforms that advance all research pillars (i.e. NSERC/CIHR I, II, III, IV))	Core platforms evaluation by research community to demonstrate impact on scholarship. # and distribution of research chairs and professorships.

REIMAGINING ENGAGEMENT – COMMUNITY PARTNERSHIP

Advance and contribute to health system partnerships, informing policy and practice	# academic faculty (UMFA/GFT) involved in projects contributing to the learning health system (e.g. CQI projects/policy development) to impact patient or system outcomes. # clinician-investigator faculty – Dentistry; Medicine; Nursing; Pharmacy; Public Health; and Rehabilitation Sciences.
Improve reciprocal community engagement through new and existing outreach programs	Survey to determine community needs. Track how community needs are being addressed. Survey to determine community satisfaction.
Increase efforts to support, coordinate and expand pathway programs	# contacts (track number of repeat contacts) with pre-university students that correlate with enrollment in university (identify faculty and program. % Indigenous students in IHP programs and professional programs.

FOSTERING A VIBRANT COMMUNITY

Ensure common core competencies in social justice, anti-racism, ableism, and anti-oppressive practices for all	% staff/faculty that have completed core modules. % learners that complete core competency modules. # Speak Up Reports.
Achieve equity, access, and participation at all levels within the Rady Faculty	Learner Diversity Survey results across all colleges. Diversity Survey of staff, faculty across all colleges. Track diversity of search committees and candidates.
Ensure culturally safe and inclusive work and learning environments that invite participation by everyone	% faculty completing ISME courses (or equivalent) – constructive evaluation / feedback, receiving feedback. % students completing courses – constructive feedback, receiving feedback. Climate Survey for Colleges.

ADVANCING RECONCILIATION FOR TRANSFORMATIVE CHANGE

Implement the revised Rady reconciliation action plan (RAP)	% faculty and staff completing cultural safety training. % completion of the 5 milestones of the RAP. % indigenous faculty and staff.
Embed Indigenous initiatives and indigenization of curricula in all programs	% units with program leads for oversight. % course or module objectives that contribute explicitly to the graduating core competencies in indigenous health. % units/students meeting requirement for a pre-entry Indigenous course.
Increase recruitment of, and support for, Indigenous learners that remove barriers	% professional programs with pre-entry pathways for Indigenous students. % Indigenous students in professional programs. Indigenous student survey evaluating support/belonging/cultural safety.

INCREASING WELLBEING AND PERSONAL ADVANCEMENT

Adopt the principles of the Okanagan Charter	Survey results of understanding/awareness of the Okanagan Charter.
Establish work and learning environments that promote balance and wellness	Baseline/Follow-up survey results on wellness. # initiatives promoting wellness. % compliance with national standard of Canada for mental health and wellbeing of post-secondary students.
Increase and formalize mentorship and professional development opportunities for faculty and staff	% new faculty assigned a mentor(s). # faculty annually participating in leadership development programs. % leaders with a defined succession plan. % staff accessing leadership and professional development.


UMANITOBA.CA

MOMENTUM:

Leading Change Together

Max Rady College of Medicine

STRATEGIC ACTION PLAN 2025-2029

DRAFT

University of Manitoba | Rady Faculty of Health Sciences

MESSAGE FROM THE DEAN

Starting in the Fall of 2022, the faculty undertook a significant consultation process to review and refresh the Rady Faculty of Health Sciences strategic plan. Concurrently, the Max Rady College of Medicine undertook a critical appraisal of its current state to develop an immediate action plan for the 2023 and 2024 academic calendar years while the Rady Faculty of Health Sciences developed its 2024-2029 strategic plan. The Max Rady College of Medicine's desired state, gap analysis and its immediate action plan that has been implemented since January 2023 can be found in Appendix 1.

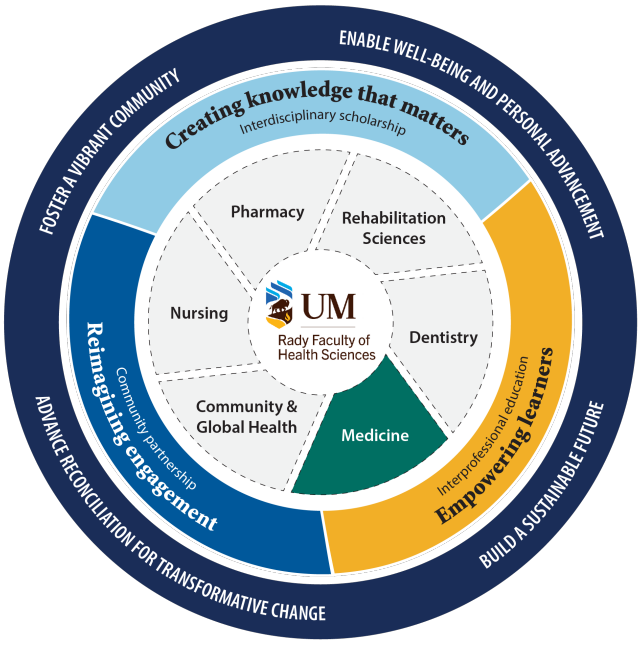
The Rady Faculty strategic plan was endorsed by the Rady Faculty Council in June 2024, which was aligned to the University of Manitoba 2024-2029 strategic plan entitled **MOMENTUM: Leading Change Together**. Central to this alignment the Rady Faculty and its constituent Colleges agreed to adopt the mission, vision, core values, as well as the strategic themes and the fundamental commitments of the University of Manitoba strategic plan.

Unique to the Rady Faculty strategic plan was the development of a mandate for the faculty, and while the strategic themes and fundamental commitments aligned to those of the University, the Rady Faculty customized the goals of its strategic plan to reflect this unique mandate. Further the Rady Faculty strategic plan developed metrics that all Colleges will use to assess annual progress.

This document contains the Max Rady College of Medicine's strategic action plan for 2025 to 2029 developed through workshops, town halls, and broad stakeholder feedback. It is to be used as a companion document to the Rady Faculty of Health Sciences strategic plan.(https://umanitoba.ca/strategic-plan)

I look forward to working together to advance the Max Rady College of Medicine as an integral member of the broader Rady Faculty of Health Sciences and the University of Manitoba community.

Dr. Peter Nickerson
Dean, Max Rady College of Medicine



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UM respects the Treaties that were made on these territories, acknowledges the harms and mistakes of the past and present, and dedicates itself to move forward in partnership with Indigenous communities in a spirit of Reconciliation and collaboration.

UM recognizes that this acknowledgment only holds meaning when reflected in the actions taken to address the injustices and barriers that have disproportionally affected Indigenous Peoples and communities, systemically preventing them from accessing and benefitting from education. Grateful for the territories and lands on which the university community learns, conducts research, and engages with external partners, UM is guided by this acknowledgment in carrying out the core work of its mission, the priorities it sets, and the decisions made to move forward as an institution.

Max Rady College of Medicine Strategic Action Plan

Strategic Theme

1. Empowering Learners – Interprofessional Education (IPE)

a) **Strategic Goal:** Focus on high quality in all educational programs, meeting the needs of the provincial health workforce.

Strategic Actions:

i. Ensure onboarding of new faculty to acquire skills and understand the standards required in educational programs.

ii. Enhance utilization of ISME & CATL offices across educational programs for CQI of curriculum.

iii. Partner with the Provincial CMO to forecast health system workforce requirements to align program resource investment.

b) **Strategic Goal:** Advance distributive models of education reaching rural, northern and remote communities.

Strategic Actions:

i. Establish a scalable distributive faculty model (network) for integrated medical education (UGME/PGME/IMG/MPAS).

ii. Develop and enact a plan to stand up a comprehensive Brandon Satellite Campus for UGME and PGME training.

iii. Create a sustainable funding mechanism and coordinating office to support student travel and housing.

c) **Strategic Goal:** Expand sustainable and cohesive interprofessional education and clinical opportunities.

Strategic Actions:

i. Create and refine IPE curriculum for asynchronous and synchronous learning.

ii. Identify and utilize existing team-based clinics in Med 1 and Med 2 for IPE observational reporting.

iii. Create IPE hubs that are resourced to support Med 3 and 4 experiential IPE learning

Max Rady College of Medicine Strategic Action Plan

Strategic Theme

2. Creating Knowledge that Matters – Interdisciplinary Scholarship

a) **Strategic Goal:** Increase interdisciplinary and collaborative scholarship that is highly competitive and impactful.

Strategic Actions:

i. Advance team-based science (i.e., funding and recognition programs, strategic recruitment and networking).

ii. Establish Clinician-Scientist minimal income base to support major research protected time (i.e., >75%).

iii. Create pathways for knowledge implementation (i.e., health system, clinical practice, and commercialization).

b) **Strategic Goal:** Advance health system and person-centered research, informed by authentic reciprocal engagement.

Strategic Actions:

i. Increase health system leaders, community leaders, or vested public on research teams as appropriate.

ii. Increase utilization of "**Learning Health System**" platforms (e.g., CHI, MCHP, Ongomiizwin, and IGPH) by health system leaders, health researchers, and communities to address unmet needs.

iii. Remove health system barriers and reduce administrative burden to conducting person-centered research.

c) **Strategic Goal:** Enhance core platforms that advance all research pillars (i.e., NSERC/CIHR I, II, III, IV).

Strategic Actions:

i. Promote core platform services across the research ecosystem.

ii. Invest in sustainability of core platforms (i.e., CFI + Provincial match funding).

iii. Client survey to assess core platform gaps to be addressed to sustain the research ecosystem.

Max Rady College of Medicine Strategic Action Plan

Strategic Theme

3. Reimagining Engagement – Community Partnership

a) **Strategic Goal:** Advance and contribute to health system partnerships, informing policy and practice.

Strategic Actions:

i. Establish a clinical governance structure to enable integration of health system & academic clinical programs.

ii. Involve government and health system leaders on pertinent committees in the MRCoM.

iii. Consolidate the framework and support for a sustainable "**Learning Health System**" across Manitoba.

b) **Strategic Goal:** Improve reciprocal community engagement through new and existing outreach programs.

Strategic Actions:

i. Identify communities that are a priority for engagement.

ii. Create a formal framework for community engagement with input from and agreement by community.

iii. Determine community needs and opportunities for partnership.

c) **Strategic Goal:** Increase efforts to support, coordinate and expand pathway programs

Strategic Actions:

i. Leverage Bachelor of Health Sciences/Studies programs as pathways to MRCoM programs (**focus:** Indigenous learners).

ii. Partner with School Boards for early exposure and support education programs for junior and senior high learners.

iii. Elevate community awareness and support for educational opportunities in the MRCoM.

Max Rady College of Medicine Strategic Action Plan

Fundamental Commitment

1. Advancing Reconciliation for Transformative Change

a) **Strategic Goal:** Implement the revised Rady Faculty of Health Sciences reconciliation action plan.

Strategic Actions:

i. Develop reconciliation leads in units.

ii. Create and advance a Community of Practice of reconciliation leads across units.

iii. Integrate actions within both academic and health system environments by clinical departments.

b) **Strategic Goal:** Embed Indigenous initiatives and Indigenization of curricula in all programs.

Strategic Actions:

i. Align Vice President Indigenous and Vice Dean Indigenous offices' action plans to maximize impact.

ii. Complete Indigenization of curricula across all programs – leverage expertise of those who have completed refresh.

c) **Strategic Goal:** Increase recruitment of, and support for, Indigenous learners that remove barriers.

Strategic Actions:

i. Recruit Indigenous faculty across all programs.

ii. Partner with other medical schools to develop a pre-admission support program to enhance access.

iii. Increase bursaries and travel grants to community for Indigenous students in all MRCoM programs.

Max Rady College of Medicine Strategic Action Plan

Fundamental Commitment

2. Increasing Wellbeing and Personal Advancement

a) **Strategic Goal:** Adopt the principles of the Okanagan Charter.

Strategic Actions:

i. Create awareness and socialize the Charter.

ii. Map the current policies in the University and MRCoM to evaluate alignment with the Charter and identify gaps.

iii. Environmental inventory of what the MRCoM is currently doing and develop a framework to move forward.

b) **Strategic Goal:** Establish work and learning environments that promote balance and wellness.

Strategic Actions:

i. Increase the amount and quality of study space for undergraduate and graduate students.

ii. Improve the quality of teaching and office space within the MRCoM.

iii. Develop a systems approach to scheduling and workflow that advance balance and wellness.

c) **Strategic Goal:** Increase and formalize mentorship and professional development opportunities for faculty and staff.

Strategic Actions:

i. Educate faculty, staff and learners through workshops on providing and receiving constructive feedback.

ii. Customize mentorship programs for both early and mid-career faculty.

iii. Formalize a professional development program for staff that creates a pathway for promotion.

Max Rady College of Medicine Strategic Action Plan

Fundamental Commitment

3. Fostering a Vibrant Community

a) **Strategic Goal:** Ensure common core competencies in social justice, anti-racism, ableism, and anti-oppressive practices.

Strategic Actions:

i. Align the Vice Provost Equity and the Vice Dean Social Justice & Anti-Racism offices' action plans to maximize impact.

ii. Embed training modules in onboarding requirements for faculty and staff (e.g., "**We will take good care of the people**").

iii. Develop leader-specific training (coaching) focused on action and implementation in units.

b) **Strategic Goal:** Achieve equity, access and participation at all levels within the Rady Faculty.

Strategic Actions:

i. Embed EAP statements and questions in all academic and staff hiring searches and interviews.

ii. Identify barriers to enacting EAP practices.

iii. Monitor EAP trends in student, staff, and faculty.

c) **Strategic Goal:** Ensure culturally safe and inclusive work and learning environments that invite participation by everyone.

Strategic Actions:

i. Workshops for faculty and staff to address issues as they occur – Call in versus Call out culture.

ii. Conduct environmental assessments of units on a regular cyclical basis and address gaps.

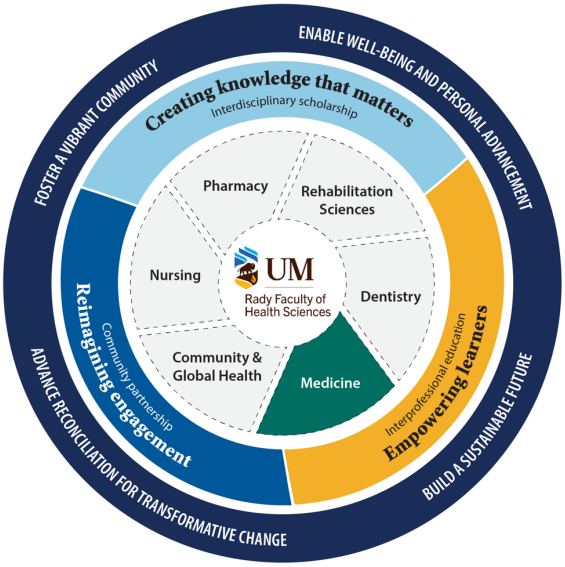
iii. Celebrate and award achievement.

Max Rady College of Medicine

University of Manitoba

Model of Excellence

APPENDIX 1



Critical Appraisal of Current State
Sep-Dec 2022

2

Max Rady College of Medicine

University of Manitoba

Model of Excellence

Brand:

- **Who people say we are**
- **How we want to be seen**

Manitoba
- Friendly and collaborative
- Value and celebrate multicultural communities
- Affordable housing and cost of living
- Vibrant art, sport and culture scenes
- **Small enough to connect & network, large enough to have impact**

Max Rady College of Medicine (MRCoM)
- Ambitious to do/be better; challenge the status quo
- Valued partnership with the Health System and Government
  - ✓ **Align strategy and investment to common goals**
  - ✓ **Foster a Learning Health System**
- Research intensive faculty driving discovery with impact
- Quality graduate education built on fdn of cutting-edge science
- Foster environments where national/international leaders emerge
- Physicians connected with MRCoM throughout their career
- Promote mentorship and career advancement
- Promote equity, access and participation
- Create safe space to hear concerns

Pre-Admission/Admissions
- Support **Indigenous communities and learners** to access programs
- Transparent/Accountable admission processes

MPAS & MSc. Genetic Counselling
- High quality programs attracting students from across Canada

UGME
- Spiral curriculum striving for high quality informed by student feedback
- Small group learning fostering outstanding clinical reasoning
- High level of support for students (e.g., Student Affairs, financial)

PGME
- Prioritize Manitoba UGME grads in PGME programs & welcome others
- **Unique IMG training pathways to practice** leveraging PGME programs

MPAS/UGME/PGME/IMG
- Exposed to a full breadth of medical case mix
- Experiential learning is high quality
  - ✓ **Independence of learning environment**
  - ✓ **Scope of exposure as the lead person**
  - ✓ **Set high expectation – responsible active team member**
- **Prioritize opportunities for distributive education**

CPD/CCA
- Support physicians acquire and demonstrate their maximum abilities

3

Max Rady College of Medicine

University of Manitoba

Model of Excellence

Confront the Brutal Facts (Fall 2022)

Medical Education Overarching Issues
- Onboarding and professional development of faculty and staff sub-optimal
- Tenuous trust between learners and faculty inhibiting constructive feedback
- Clinical preceptor capacity rate limiting for sustainable program expansion
- Infrastructure insufficient to support program expansion
- Remuneration not standardized for physician faculty across/in departments

Admissions **Principle – graduates should reflect the communities we serve**
- Insufficient training seats available [110 seats (78/mil pop); >800 applicants]
- Low # of Indigenous students prepared to enter medicine

UGME **Fully accredited program (unique in Canada) – next cycle 2027**
- Lack of generalist role models in Med 1 and Med 2
- Lack of standardized small group longitudinal learning in Med 1 and Med 2
- Curriculum refresh required to address gaps and advances in medical education
- Gaps in student supports (e.g., bursaries, funding for distributive education)

PGME **Major gaps identified in 2022 accreditation – critical review in 2024/25**
- Lack of detailed workforce needs assessment
- Key programs not optimized to meet all accreditation requirements
- Recruitment of MB graduates sub-optimal [71% Generalist; 50% Specialists]
- Assessment and training of International Medical Graduates (IMG) is sub-optimal

Clinical/Biomedical Graduate Education & Research Programs
- Research potential not fully realized
- Graduate student stipends not standardized nor optimized
- Need to enhance interdisciplinary education and research
- Lack of funding mechanisms for Clinician-Scientists
- Limited support and incentives for commercialization of novel discoveries/knowledge – lost economic opportunity for MB
- Core facilities require scope optimization and updating
- High administrative burden & barriers to basic/clinical research
- Lack of health system prioritization of research as a foundational part of creating a "**Learning Health System**"

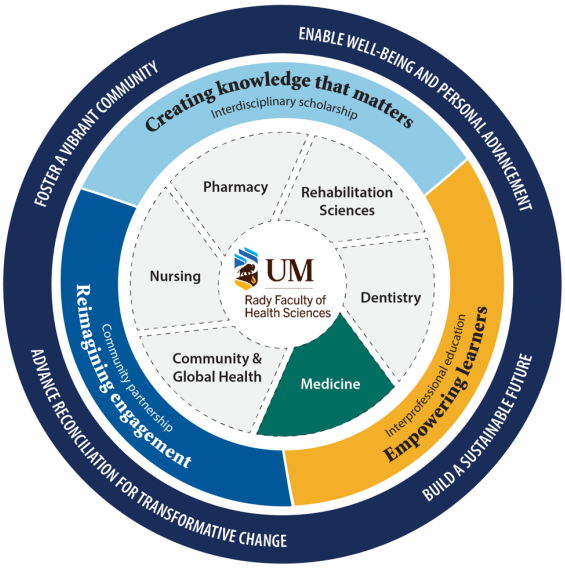
Master of Physician Assistant Program (MPAS)
- Sub-optimal training seat numbers given workforce demand
- Financial burden excessive for students
- Access to experiential training sites in competition with others

Master Science in Genetic Counselling
- Financial burden excessive for students
- Number of faculty & placements limited to deliver the program

4

Max Rady College of Medicine

Model of Excellence



Immediate Action Plan 2023-2024

5

Max Rady College of Medicine

Empowering Learners
Reimagining Engagement

Model of Excellence

We meet the **health needs of individuals and communities in Manitoba** and beyond

We deliver high quality **medical professional** and graduate **education**

Immediate Action Plan 2023-2024

Admissions – Refresh non-academic and academic attributes to minimize socio-economic barriers to access

UGME – Refresh curriculum, imbed generalists in pre-clerkship, mock accreditation in 2025, expand capacity to 140/yr

PGME – Address 2022 accreditation gaps & implement full expansion by 2025, develop post-training retention strategies

Brandon Satellite – Expand PGME, partner with PM-RHA and BU to propose a comprehensive UGME satellite campus

IMG – Implement expansion of the 1-year family medicine program, create & expand generalist/specialist PRA programs

CCA/CPD – Address 2024 accreditation gaps, support PALS and ATLS program delivery/expansion, expand CCA capacity

MPAS – Implement class expansion in 2024/25 and consider potential further expansion in 2027/28 as required

6

Max Rady College of Medicine

University of Manitoba

Empowering Learners
Creating Knowledge that Matters

Model of Excellence

We deliver high quality **medical** professional and **graduate education**

We value, embed, and advance **scholarship and innovation** in our programs

Immediate Action Plan 2023-2024

Vice Dean Graduate & Post-Doctoral Studies → graduate student professional development initiatives (85% non-academic)

Graduate Students – Increase grant # / $ value to backfill lost funding from Research Manitoba and address cost of living

Research Associates – Standardized pay grid for entire Rady Faculty of Health Sciences

Vice Dean Research → review & consultation on research enterprise effectiveness and impact

National grant applications – Chalk talks by departments; external reviewer & grant polisher funding

CIP Director → National evaluation of barriers to advancing Clinician-Scientist careers in Canada

Chairs (new) – 1 **Neuro Trauma** (Surgery), 1 **Clinical Stroke** (Int Med); CRC Tier 1 – **Neuroscience** (HACS), Tier 2 – **AI** (CHS)

Professorships (new) – 2 **Neuro Imaging** + 1 General Imaging (Radiology), 1 **Indigenous Health** (CHS), 1 Anesthesia

Equipment (new) – CFI Innovation fund & JELF – multiple awards; Rady FHS investment in state-of-the-art lab equipment

Facilities (new) – Pandemic Pathogen CL3 Lab, Genetic Modeling Fish Lab, High Resolution Imaging Labs

7

Max Rady College of Medicine

University of Manitoba

Empowering Learners
Creating Knowledge that Matters

Model of Excellence

We deliver high quality **medical** professional and **graduate education**

We value, embed, and advance **scholarship and innovation** in our programs

Immediate Action Plan 2023-2024

College of Community and Global Health – Finish standing up independent from College of Medicine

- Transform the **Bachelor of Health Studies** → **Bachelor of Community Health Sciences** assigned to the College
- Advance expertise in Social Determinants of Health, Social Justice & Health, Health Policy & Administration, and Data Sciences

School of Biomedical Sciences – Develop a proposal to establish inside the College of Medicine

- Aggregate the biomedical science departments under the umbrella of a Director and School Council
- Expand the **Bachelor of Health Sciences** from **40** → **100 seats**/yr and embed it as a foundational degree program for the School
- Potential for a MSc/PhD in Health Sciences as a pathway to train clinician-scientists focused on translational science

8

Max Rady College of Medicine

Fundamental Commitments

Model of Excellence

We foster **safe environments** where **learners, faculty and staff** are **healthy and fulfilled**

Immediate Action Plan 2023-2024

- Ongomiizwin – Indigenous Institute of Health and Healing
  - ✓ Expanded wrap around program of learner support with Elders and Indigenous mentors
  - ✓ New Indigenous Cultural Safety Training program – ***We Will Take Good Care of the People***
- Mentorship Program – serving Black, disabled, Jewish, Filipino, Muslim, 2SLGBTQIA+ learners
- Formal curriculum for students
- Formal seminars for faculty and staff

  } on anti-racism and hate speech in social media
- Recruitment of Director of Professionalism for Rady Faculty of Health Sciences
  - ✓ Developing Professional Unsuitability Bylaw in all our professional colleges
- ISME Office: Onboarding faculty, staff and students regarding critical conversations, constructive feedback

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Rady Faculty of Health Sciences

Fundamental Commitments

Bannatyne Campus Renewal (2024-2027)

Ongomiizwin – Indigenous Institute of Health and Healing

Dental Clinic – undergraduate & graduate, and dental hygiene training

UGME – lecture theatres, classrooms, and simulation centre

Pre-School/Day Care – support students, staff, and faculty

10

COUNCIL MEETING - MARCH 19, 2025

FOR INFORMATION BRIEFING NOTE

SUBJECT: Restorative Practices Program Update

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 initial steps of hiring a team to administer the Restorative Practices Program is nearing completion. Conditional offers have been extended to a Medical Consultant and a Program Coordinator, planning is underway for April orientations. To broaden community connections and partnerships, two contracts have been offered, one for an Indigenous Health Specialist Physician who will inform the framework of the program and one for a Knowledge and Translation Specialist who will support CPSM in supporting anti-Indigenous racism initiatives.

The Medical Consultant and Program Coordinator will develop a multi-year action plan guided by the Indigenous Health Specialist Physician and Translation Specialist 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

An operationalized Restorative Practices Program will be foundational to the successful implementation of the Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism.

COUNCIL MEETING - MARCH 19, 2025

NOTICE OF MOTION FOR APPROVAL

SUBJECT: **M3P - Codeine**

BACKGROUND:

On December 18, 2024, Council approved consultation be sent to registrants, stakeholders, and the public on whether non-exempted codeine products should be added to the M3P schedule.

On January 13, 2025, CPSM notified registrants, stakeholders, and the public of the consultation being open until February 18, 2025. A reminder was sent to registrants on February 5, 2025.

In total 35 responses were received - 30 from registrants, 3 from stakeholders, 2 from the public. The response at attached as ***Appendix A***.

The responses are robust and should be carefully reviewed. Due to the nature of the comments, it is difficult easily categorize them. That said, a high-level overview is of the 35 received, 17 were in favour of adding the non-exempted codeine products to the M3P schedule, 10 were opposed, and there were 8 responses providing observations that could arguably be categorized as being either in favour or opposed.

The primary reason for opposition to adding non-exempt codeine products to the M3P schedule is the increased administrative burden. Of note, 4 of the 10 registrants opposed cited increased administrative burden associated with using the duplicate prescription pads (sometimes referred to as “triplicate” which are no longer available as of August 13, 2024). If registrants were required to use the old duplicate handwritten prescription pads there may be legitimacy to this concern. However, the use of CPSM recommended prescription templates in EMRs reduces the time spent filling out prescriptions, improves readability, and can be sent directly to the pharmacy. The only additional administrative burden is including indication, ensuring one drug per prescription/page, and ensuring the total quantity is present in numbers and words (this latter requirement is already included by default in most EMRs). The administrative burden is minimal and must be weighed against patient and public safety.

Additional concerns related to adding non-exempt codeine product to the M3P schedule is that it will result in patients not receiving pain medication that they require. Having a drug listed on the M3P schedule does not prevent it from being prescribed to individuals who require it.

Important knowledge gained from the consultation responses is that there is an opportunity to communicate with registrants related to improved opioid prescribing. CPSM will initiate communication to registrants related to proper opioid prescribing and the use of EMRs for prescribing.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Non-exempt Codeine products be added to the M3P schedule, effective Monday June 2, 2025.

Comment
Although certainly well intentioned, the M3P program has been a complete failure in terms of reducing narcotic addiction in the population. Manitoba, and other jurisdictions with similar "triplicate pad" type programs such as BC do NOT have lower addiction rates than jurisdictions with them. I have worked in provinces with and without such programs and there is no advantage to patient outcome that I have ever seen. Additionally, these programs directly cause harm by 1) wasting physicians time which is precious and could better be spent on actual patient care or dealing with burnout and 2) wasting public resources with the tax dollars and bureaucratic blot needed to maintain such programs. We do not have tax dollars to waste on someone's pet projects without clearly demonstrable improvements in patient care. Doubling down on a failed program by adding things like codeine is simply embarrassing and should be avoided. The only upside to adding codeine would be surgeons likely moving more to better narcotics such as hydromorphone or tramadol which have a cleaner pharmacological profile.
While I appreciate the general goal the college is trying to achieve by removing codeine products from the exemption list, I have several concerns with the material presented. 1. the statement that codeine is the main contributing cause of opiate related overdose deaths. This is untrue even based on your own data presented. Fentanyl, according to your most recent data, is. 2. Diphenhydramine is involved in nearly as many overdose deaths and yet remains available without prescription. Why is the college not targeting this product in any way? 3. Creating barriers to opiate prescription for chronic pain patients who have already been on them long term can contribute to the rise of illicit opiate sales, usually containing fentanyl as we have seen in many jurisdictions. As mentioned, while I support the general idea, I do not think making more codeine products m3p will have much effect on the prescribing rates or overdose death rates. It seems like the college should be focusing on reducing the use of fentanyl products by opiate dependent individuals by any means necessary.
I strongly approve of this change and feel it has been a long time coming. Thank you.
I would support the addition of non-exempted Codeine products o the M3P program .
I would like to share my very strong opposition to adding Tylenol #3 to the Manitoba Prescribing Practices Program (M3P). [redacted] Tylenol #3 is one of the most common medications I prescribe. I have the requisite training and knowledge to know if/when this medication should be prescribed. Adding it to the M3P program will not affect my practice pattern, or result in fewer prescriptions for Tylenol #3 (which I am assuming is the CPSM's rationale/intention for taking such an approach). This decision will not only add to the administrative burden physicians face, but will also have a negative impact on patient flow.

I humbly ask that the CPSM reconsider and ultimately reject this proposal.
I strongly disagree with adding Tylenol #3 to the triplicate list. The changes required for safe prescribing practices come from better patient and practitioner education. this change will not limit opioid prescription, but rather only add a further administrative burden to the province by making the regulating body handle a much larger number of reviewed prescriptions.
I agree with the proposed changes regarding Codeine and MP3.
Codeine is a drug that is metabolized to morphine (in some individuals). It is a bit of a Trojan horse in two ways. It is really morphine to some people (good metabolizers) and placebo to others (poor metabolizers). It is a drug that has little merit and educational efforts should be made to encourage it not to be prescribed. It is unclear why it is used at all when more efficacious and simpler metabolism medications (eg morphine) with greater clarity of mis-use risk are available. I see this step (making Rx more difficult) as a welcome step towards the disappearance of codeine products. On a separate but related note, are there any plans to address deprescribing? As our population ages and medical complexity increases there is an epidemic of iatrogenic illnesses related to polypharmacy.
If Tylenol 3 is added to the M3P list, I would suggest taking/keeping Tramacet off of it.
Regarding the email attached, I'm not able to responsibly comment as I do not know the absolute or relative safety data for these drugs (esp. T3s) compared safety/toxicity of other drugs that are not part of this program. The proposed changes will restrict qualified care extenders from prescribing the drugs and make it more difficult for patients to access, even temporary, pain measures on an 'on call' basis (that is, when a physician is providing on call coverage to a large population of patients, the inability to call is a temporary prescription for a patient having pain on a weekend could mean that might need to present to an overburdened urgent care clinic or ER to be assessed or prescribed acetaminophen with codeine. How the change in prescribing practices objectively modifies harms however are not data I'm familiar with. Will this change result in net benefit? Weighing the impact of this proposed changed with the actual and evidence-informed modifiable reduction in harm associated with the proposed is important. Given current prescribing permissions, are the risks of Tylenol #3 consistent with, or out of proportion to, other drugs prescribed under similar prescribing permissions? [redacted] I see effects of drug toxicities due to interactions and overdoses across many drug classes including iron, calcium channel blockers, anti-coagulants, benzodiazepines, anti-depressants, etc. If T3 toxicity is out of proportion to the toxicity and potential harms of these and other agents, then this change could very well be justified. On the other hand, if comparable toxicity occurs within these

other drug classes which can also be ordered by NPs and ordered verbally, etc, then the rationale to support the isolated reclassification as proposed feels more unclear. I'm not opposed to reclassification or change in the interest of patient or public safety. Prior to a change occurring however, I'd like Manitoba to ensure disproportionate harm exists to support an isolated change prescribing permissions, and that satisfactory evidence of harm reduction exists to support the proposed. Such data will also permit us to understand the unintended (and potentially negative) consequences of the proposed change. Ultimately, the decision should be based on data rather than testimonials or other geographic practices or opinion. Can we make this a data-driven decision?
I would suggest that products containing 10mg or more of codeine should be in the M3P programme.
Is there a concern that omission of Tylenol 1 will result increase incidence of Tylenol toxicity as clients feel driven to larger quantities in order to achieve the desired effect
I would like to extend my support for the initiative to add codeine to the M3P list. As codeine is effectively providing a patient an unknown dose of morphine due to variable metabolism, it does not make sense that this has historically not been included in this category. Furthermore, the ease of prescribing Tylenol #3 in particular, has led to an overabundance of use in the general population. As someone who trained out of province [redacted], the amount of Tyl #3 I have seen prescribed throughout my career in MB, can only be described as excessive. Additionally, with mounting research showing non-inferiority of appropriate dosing of acetaminophen plus NSAID to acetaminophen/opioid combinations for multiple types of pain, the use of any opioid medications should be dropping. A focus on educating currently prescribing MDs, as well as ensuring appropriate education to trainees, is paramount to reducing the massive opioid burden affecting our province, as well as throughout Canada.
I'm an [redacted] in Winnipeg and see the consequences of opioid addiction regularly. In my view codeine should never have been treated any different than all other opioids and I am happy that the regulations are changing. However, I do not understand why 8mg codeine products are exempted. I am aware that the stated rationale is "exempted products excluded to maintain patient access", however there are several flaws with this. The implicit assumption is that patient access to 8mg formulations of codeine is critical to maintain, but studies have not demonstrated effectiveness. A CADTH review found "No relevant evidence regarding the clinical benefits or harms of medications containing low-dose codeine (i.e., 8 mg of codeine or less per tablet or 20 mg of codeine or less per 30 mL in liquid products) alone or in combination with additional non-narcotic medicinal ingredients for the treatment of pain was identified; therefore, no summary can be provided." A Cochrane review found only 2 studies of codeine for cough, both of which did not show benefit, and used much higher doses than 8mg. Leaving efficacy aside, it simply makes no sense to allow sale of 8mg products without a physician prescription while requiring a prescription for higher strengths. This would be like allowing a person to buy 8 slices of pizza individually, but not a whole pizza. A patient with opioid use disorder will simply take double the number of T#1 than they would T#2 and in the process increase the risk of acetaminophen toxicity. Furthermore, if we follow the logic that patients need easy access to 8mg codeine, pharmacists should be able to prescribe low doses of all opioids. Why not have them prescribe half tablets of morphine 5mg?

Patient access to opioids seems to be a bizarre concept in a regulatory environment where topical retinoids for acne are by prescription only. If the colleges are truly concerned about lowering barriers to care I'd welcome a review of what medications are available OTC and via pharmacists without physician involvement.

My recommendation would be that there are no exempted codeine products, all codeine containing products should be on the M3P list.

[redacted]

My references are below:
CADTH Health Technology Review
Medications Containing Low-Dose Codeine for the Treatment of Pain and Coughs
Rapid Review
Authors: Calvin Young, Hannah Loshak
https://canjhealthtechnol.ca/index.php/cjht/article/view/rc1374/251
Smith SM, Schroeder K, Fahey T. Over-the-counter (OTC) medications for acute cough in children and adults in community settings. Cochrane Database Syst Rev. 2014 Nov 24;2014(11):CD001831. doi: 10.1002/14651858.CD001831.pub5. PMID: 25420096; PMCID: PMC7061814.

I am very much against the concept of requiring Tylenol three to be on the MP3 list. This is a relatively low dose of codeine. I think prescribers have done an excellent job of reducing the amount of narcotic provided. It would just create an extra Burden that is entirely unnecessary and is unlikely to benefit the greater population.
It seems like window dressing.
We keep getting emails weekly about how Doctors Manitoba is chasing reducing our administrative burden.

[redacted]

I am writing to express my concerns about the proposal to require that analgesics containing codeine to be written on duplicate prescription forms. I have practiced [redacted] in Manitoba for over 30 years. I routinely prescribe Tylenol #3 as a postoperative analgesic for my adult patients. I am aware of no significant adverse outcomes experienced by any of my patients related to their use of this medication.

Additionally this change will be very inconvenient for surgeons as we will no longer be able to use the hospital-supplied Rx forms. What happened to "reducing administrative burden" on Physicians?

The proposed changes won't reduce the number of Tylenol #3 prescriptions written. It will only make it more difficult for us to prescribe it.

See ADDENDUM 1
As a [redacted] who often prescribes small dose of Tylenol #3 for postoperative pain. I comply with recommendations for postoperative prescribing and often provide 15 or less tablets on the prescription. My suggestion would be to limit needing an MP3 prescriptions for medications including Tylenol 2 or 3 to for only over certain amounts, such as over 15 or 20 tablets.
Thank you for the opportunity to provide feedback on this proposed change. I'm concerned the evidence for moving codeine onto M3P as presented in the supporting documentation is not strong, and there will be a substantial administrative burden to implement moving codeine products onto M3P. I believe the Quality Prescribing Working Group should revisit the rationale and the supporting evidence for this change and attempt to make a more compelling argument. A broader review of M3P program processes and procedures would also be helpful. The rationale for the change is stated as "Codeine contributes to more overdose deaths than any other opioid in Manitoba", and it is additionally noted that codeine is not safer than other opioids. Four slides are provided as supporting evidence but the data on these slides does not provide evidence that codeine not being on the M3P program is associated with increased risk of overdose death. Slide 2 shows that there are about twice as many codeine users as all other opioids combined but slide 4 shows that codeine is associated with only about the same number of overdose deaths as all other opioids combined. While codeine is associated with an absolute number of overdose deaths that is greater than other opioids, that appears to be more of a function of how often it is prescribed, which in turn is probably a function of being easier to prescribe. If codeine is only as safe as other opioids it should be associated with twice as many overdose deaths as other opioids because there are twice as many codeine users. Further, since it is not on the M3P program, one might argue it should be associated with an even greater number of overdose deaths. In reality, codeine is associated with fewer overdose deaths than one would expect. One plausible interpretation of this data is codeine is safer than other opioids. Another interpretation, though counter intuitive, is that if codeine truly is only as safe as other opioids, then having codeine not on the M3P program is associated with reduced risk of overdose death. There is a significant administrative burden for the province's physicians to adopt M3P prescribing practices for all the prescriptions of all those codeine users, approximately 120 per 1000 or 12% of the population, about 170,000 of Manitoba's 1.4 million citizens. With about 25 overdose deaths per year where codeine is associated, this works out to about 1 in about every 6800 codeine users, and for some of those codeine users there are probably other opioid and non opioid substances involved in the overdose death as well. This relatively rare event needs to be placed in context with the administrative burden, especially given the current partnership between the province and Doctors Manitoba of reducing physician administrative burden to help patients access care. Contrast this with oxycodone, about 10 overdose deaths per year against 10 per 1000 users (1% or 14,000 users province wide), so one overdose death per about 1400 users. Since the evidence presented in the slides and other supporting documentation is not strong, the Quality Prescribing Working Group should revisit the rationale for moving codeine into the M3P program, ensuring the expected benefits justify the administrative burden and potential

physician access issues. What has been the experience in other provinces when codeine is moved onto M3P type prescribing? Are overdose deaths reduced? What has the Manitoba experience been with overdose deaths since tramadol was moved onto M3P? Are there benefits besides reducing overdose deaths that would be expected from moving codeine onto M3P? The purpose of the M3P is to prevent diversion of prescription opioids, which is a much larger problem than overdose deaths. What is the evidence in support of M3P type programs preventing diversion in our current prescribing environment, complete with a province wide DPIN Database?

The Quality Prescribing Working Group seems to be of the opinion that moving codeine onto M3P will result in fewer opioid prescriptions/ opioid users because the ease of prescribing codeine makes physicians prescribe an opioid without an indication for doing so. Is there any evidence for this from the other provinces where codeine was moved onto M3P? I fear that if all opioids require similar administrative burden to prescribe, physicians may be asked to, or choose to prescribe other opioids like oxycodone, that are associated with increased risk of overdose death compared to codeine, as per above.

Finally, has the Quality Prescribing Working Group reviewed how programs in other provinces that are equivalent to M3P are run? There may be opportunities to optimize the efficiency and safety of our own M3P program. Anecdotally I understand other province's programs are not as administratively burdensome as Manitoba's M3P program. The M3P program also predates the DPIN database which is an easily accessible tool for identifying opioid dispensations at high risk of misuse and diversion. Reducing the physician administrative burden of the M3P program in combination with incorporating codeine into M3P would be a broader win for stakeholders than the current plan is, assuming there is a strong patient safety argument to begin with.

Thank your again for offering this consultation.

[redacted]

Yes add

No thanks

In your rationale you state that it pertains to the fact that codeine has been shown to be a primary contributor to overdose/death. This is an accurate statement. But is it germane to the issue?
The more relevant question is whether your efforts will lead to any significant impact on the problem such that cost of implementation is well worth it.

It would seem to me that all physicians are united in their desire to see reduction in addiction and death in our society. My understanding is that is it a very complex disorder and access to Tylenol with codeine is not at the root of the problem. I really wonder how reduction in the overall prescribing of opiods will impact on addiction rates or death rates. Of course you will see that the deceased is less likely to have opiods in their blood stream but they are still vicitims of the disease. Nothing has substantially changed. You need to see a reduction in people experiencing addiction and death. You do not present any data to support this hypothesis. I recall we went through a similar exercise with benzodiazepines a few years ago. Has your intervention of limiting dispensation to a 30 day period led to less deaths? Is anyone following the data after your intervention? [redacted] I prescribe opiods and benzodiazepines for the management of acute pain, procedural pain and for chronic pain. I will continue to pull out my script and comply with whatever paperwork is required of me. I would like to think that I am contributing to some goal in our community to reduce drug addiction/death but I really do not believe this is it. Rather, I think the initiative you propose is almost dismissive of the complexity of the problem. Finally, when you do bring in reforms, I think you should remain interested in the problem and determine whether your well intentioned ideas bear the fruit you had hoped for.
I strongly support the initiative to include more codeine products in the M3P program. I woild comment that I beieve that the 8mg codeine products realy should be taken off the market or at the least included. The narcotic use graph was an eye opener. Codeine is obviously a narcotic of xonvenience. I was also shocked at the oxycodone use. I think the College has done on a good job educating the membership on that.
I would like to submit my feedback on the proposal to add non-exempted codeine products to the M3P program. [redacted] I rarely prescribe codeine-containing or other opioid medications; therefore, I would prefer not to have to go through the process of registering for M3P for the occasional times that I do. I also work in [redacted], where I receive frequent requests for opioids, and being able to tell patients that I am not licensed to prescribe them makes it much easier to decline these requests. That being said, I do have a need to prescribe Tylenol #3 occasionally for patients with post-liver biopsy pain or acute pain from hepatocellular carcinoma, and I would like to be able to retain this ability without registering for M3P. The rationale for the proposed change states that "Codeine contributes to more overdose deaths than any other opioid in Manitoba"; however, the Health Canada data (https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/) don't seem to support this. They report that 79% of opioid toxicity deaths in the first half of 2024 involved fentanyl, and 82% involved opioids that were non-pharmaceutical. While these are national data, they are similar to what I have seen for patients in my clinic who use drugs. Is there a reference to support the statement about codeine? I worry that this change will create another layer of bureaucracy for physicians, without actually making patients or the community safer. As well, if people who use drugs have a reduction in their access to Tylenol #3 (which is

prepared under controlled conditions and has a known/consistent amount of opioid), they will replace this with other street drugs that are less defined in content and potency, which may paradoxically increase the risk of drug poisonings/overdoses.
Regarding the proposed changes to codeine products I must share my concern about the practicalities of this proposal. I recognize that this is a frequent drug of abuse through the sheer number of prescriptions that are likely employed. However the other side of this equation is leaving patients in under-treated pain due to making cumbersome PPP requirements. I think a fair middle ground would be to require indication for Rx to be written and for the number of tablets to be in numeric and written form Ex 20 (twenty).
I would agree with the addition of non-exempted codeine products to the MP# drug list
See ADDENDUM 2
I support Tylenol 2 and 3 being part of the Manitoba Drug Monitoring Program. I don't support pharmacists being able to prescribe Tylenol 1. I have seen many people with opioid addiction misusing Tylenol 1. I believe there should be a separation between prescribing and dispensing of medication. Thanks for the opportunity to give input.
I am writing to express my concerns regarding the recent decision to add non-exempted codeine products, such as Tylenol #2, Tylenol #3, and Cotridin liquid, to the Manitoba Prescribing Practices Program (M3P) drug list. While I recognize the importance of addressing opioid misuse, these new restrictions create unnecessary burdens on already overwhelmed prescribers and limit access to short-term pain management options for patients who genuinely need them. The majority of codeine prescriptions in clinical practice are for **short-term, limited use**—such as post-procedural pain management following [redacted] procedures. These prescriptions typically range from **10 to 30 tablets**, and patients rarely require more than one or two courses per year. There is **no significant evidence** that such short-term use contributes meaningfully to opioid addiction when prescribed appropriately. The new M3P requirements will: 1. **Increase Administrative Burdens:** Requiring a separate prescription form for codeine products, prohibiting verbal prescriptions, and mandating additional documentation will add unnecessary delays and paperwork, straining physicians and clinic staff who are already managing high patient volumes. 2. **Limit Access to Pain Management:** Physician Assistants and Clinical Assistants will no longer be able to prescribe these medications, which will reduce access to timely pain relief for patients. This is particularly concerning in rural and underserved areas, where access to primary care physicians is already limited.

3. **Disrupt Patient Care Without a Clear Benefit:** The restriction requiring pharmacies to receive prescriptions within **three days** may result in unnecessary patient visits and logistical challenges, especially for those with limited mobility or transportation access. Given these challenges, I strongly urge the College to consider **an exemption for short-term prescriptions** of **10 to 30 tablets, limited to 1–2 times per year**. This would allow physicians to continue providing appropriate, short-term pain relief while maintaining responsible prescribing practices. I appreciate the College's efforts in addressing opioid misuse, but I urge you to consider a more balanced approach that does not place excessive burdens on physicians or hinder patient care. I welcome the opportunity to discuss this matter further and explore solutions that prioritize both patient safety and practical clinical workflow. Short term prescribers don't want to go through rigors of MP 3 training. They like an out of saying they aren't MP3 trained for those seeking stronger drugs as well they can say sorry I'm can't prescribe hydromorphone etc and keep the weaker drugs in play. We don't want the extra paperwork and hassle but need some short term options Please just limit numbers to maintain oversight
Thank you for asking my opinion about adding codeine products to the M3P list. I had not replied to your earlier request because I think it is a fine thing to do. Thank you.
We would like to voice our strong objection to the addition of non-exempted codeine products to the Manitoba Prescribing Practices Program. After reviewing your data, we find your rationale for this move confusing. Your own data demonstrates that the prescription rate for codeine is decreasing. Your data also shows that the highest rate of opioid deaths from highest to lowest numbers is due to fentanyl, methamphetamine, cocaine, ethanol, benzodiazepines, and then codeine is on par with SSRIs. Given this data, we are wondering why the SRRIs medications also are not going to be placed on the MPPP if they cause the same number of deaths? Further, benzodiazepines cause more deaths than codeine and yet it is not on the M3P. The rationale is not consistent with the goals of fewer deaths. For those of us who work in clinical practice, we are all well aware that the use of codeine products is invaluable to patient pain control, and that most if not all physicians are extremely careful with prescribing these drugs. Part of the reason that these medications are so popular to prescribe is that they are effective and easy to prescribe. If one were to ask why other opioids are not more frequently prescribed, it is simply a function of our expertise (or lack of) and time constraints. Other opioids are not prescribed as frequently for 3 reasons. Prescribers are not as comfortable with side effects of stronger opioids such as hydromorphone or morphine, patients are UNWILLING to take many opioids, (we have even had palliative patients refuse) as they are terrified of becoming "addicts," (despite having real pain issues), and the triplicate medication prescriptions take an enormous amount of time to write out, has only a 3 day window for filling the prescription, and they are always complicated by calls from pharmacies. As a result, the traditional Tylenol #3 has been a mainstay prescription. Patients are comfortable with this medication for pain control and often refuse anything else.

The first clinical concern for this change includes the very high likelihood that clinical physicians will see more GI bleeds as patients turn more and more to NSAIDS (ex. Naprosyn) for pain control when they are unable to receive adequate codeine products. The emergency departments are not able to keep up with the demand from the public currently, so these preventable GI bleeds will strain ER services even further. If this medication is placed on the MPPP, fewer physicians will supply triplicate prescriptions, and patients will use more over the counter medications that are not monitored or followed up by physicians.

Not only are GI Bleeds a concern, but hyper-anticoagulation is also a very real patient risk when turning to NSAIDS for those patients on coumadin for A. Fibrillation and artificial valves, DAPT for CVA prevention, apixaban for Pulmonary embolism, afib etc. There are many, many elderly patients on blood thinners that remain fall risks. Taking away a pain medication to be replaced by an over the counter one, is paramount to disaster in the form of increasing fall complications in the anticoagulated patient, (SAH, ACS, Fractured hips etc).

If physicians are only able to prescribe T#1 for pain control, the ERs/UCs are going to see far more Tylenol overdoses as patients end up taking more acetaminophen #1 to try and achieve adequate pain control. Instead of taking 1-2 Tylenol #3 for pain control, they will end up taking two to three times as many T#1 to have the desired pain control. This will put them at risk for an acetaminophen overdose, including but not limited to hepatitis, hepatic failure and death.

Secondly, our Dental Colleagues, including our Oral Surgeons, do not possess triplicate privileges for pain control. They rely on Tylenol #3 (with codeine) for pain control following painful procedures such as dental extractions, dental abscess drainage, root canals etc. If they do not have the ability to prescribe Tylenol with codeine, their patients will not have adequate pain control. Further to this, patients will need to see their own physicians following dental procedures to receive adequate pain treatment. At this current time with medical physician shortages, the last "extra work" that physicians need is to see dental patients for pain control. This will be difficult to organise for patients. Dental abscesses are not planned occurrences and one cannot rely on NSAIDS due to fresh bleeding risks, so this change will require patients to see a physician in very short and unexpected order following their procedure. This again will put more burden on patients and physicians for adequate care.

Thirdly, and most importantly, we ask the College, **why does Manitoba even have MPPP medications?** We are the only province in Canada with this type of prescribing rule. In every other province, any medication can be written on a standard prescription pad. These prescriptions are then tracked by the pharmacy college and prescribing practices are sent back to the Physician College to be reviewed, if there are discrepancies in prescribing patterns. With the advent of electronic records and the Drug Profile Information Network (DPIN), medications and prescriptions are easy to track and compile. At this time of trying to have consistent practices across the country, why is Manitoba the only province to have this type of system?

In short, it is an outdated system which burdens both patients and physicians.
In a bid to improve the clinical physicians' efficiency and be on par with other Canadian Physicians, we would advocate to disband the entire M3P. Physicians should be granted the ability to provide clinically justified pain medications in a timely manner without undue administrative burden.

Continue with physician and public education with respect to pain control measures and safety. Allow dentists to provide the appropriate dental care and pain control for their own patients without the need for physician involvement. Allow our College to be modernised and on side with the other Canadian provinces prescribing standards.
Comment
I have review both public consultation requests; Addition of non-exempted codeine products to the Manitoba Prescribing Practices Program (M3P), and Amendment to Practice Direction-Professional Practice and Inactivity. [redacted] has no concerns with either proposal.
Good afternoon, on behalf of [redacted], I'd like to share feedback in support of these suggested changes as we also want positive client and public outcomes. We ask for notification of changes to the M3P program, so that we are able to keep Nurse Practitioners apprised, as their prescribing practice expectations require their prescribing decisions are in alignment with the M3P program.
Thank you for the opportunity to provide feedback regarding the proposed addition of non-exempted codeine products to the Manitoba Prescribing Practices Program (M3P). Should you have any questions or concerns regarding the attached, please feel welcome to contact me. See ADDENDUM 3
Comment
[redacted] I'm 56. I've already had a hip replaced and am on the waiting list for knee replacements. At present I deal with arthritis throughout my body - hands, feet, ankles. I have stenosis in my neck and back that cause excruciating charly-horse type muscle spasms that keep me up all night crying and screaming into my pillow. I can't take n-saids because of an extreme allergy. I want to kill myself sometimes because my pain is so bad and I can't get anything to help. Lyrica helps but has caused weight gain, making my issues worse. I have no history of drug abuse. I have no interest in becoming a prescription drug addict - I watched my mother's family doctor give her whatever dangerous opioid she requested. It turned her into a lifeless zombie with no interest in her family.

I can appreciate that you want to prevent this as well - but your reactionary approach has become so extreme that my own family doctor will not prescribe anything that might touch my very real, very extreme pain (not discomfort, pain), even for a short term, so that I might have at least one night of restorative sleep. He's afraid you will investigate him. You need to take a more balanced approach, unless you are wanting more Manitobans my age apply for requested suicide. I can't live like this anymore. It's cruel to expect me to. Kindest regards, [redacted]
I would agree to both rules being changed as recommended by the College, requiring special prescriptions for all codeine medications and removal of time restrictions from the regulations regarding family practitioners involvement in obstetrical practice.

ADDENDUM 1

[redacted]

College of Physicians & Surgeons
Winnipeg
Manitoba

February2nd 2025

Re Codeine Consultation

I would like to submit the following::

Please, please be careful what you wish for. I can fully understand your reasoning, on occasion codeine is a scourge. BUT if this product is designated to M3P there is little doubt that its use will be reduced. It is also certain that other products will replace it use, products that will be considerably more harmful. There is little doubt that marijuana in all its strengths will become a replacement product supplied in various forms on the street, but far more concerning to me, is that Lyrica {pregabalin}, Cymbalta [duloxetine] .and other drugs will increase in use and the side effects may well be far more severe than what is occurring at present. It is also a concern that more patients are becoming allergic to NSAID's, and these medications are also not available due to side effects involving BP and gastric issues.
Lastly, probably not a major concern for most patients, but codeine products are generally cheap, and this change could well negatively affect those on tight budgets.

[redacted]

ADDENDUM 2

[redacted]

College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg
Manitoba
R3J 3T7

6th February 2025

Submission to CPSM

I was shocked to see in the Email which I received from the College on January 20th 2025 that "Codeine contributes to more overdose deaths than any other opioid in Manitoba"
My understanding has been that at the present time Fentanyl was by far the major cause of inappropriate drug overdoses.
Unfortunately, the definition of drug overdose is rather vague as is it now used to refer to a number of situations:

a) **Deliberate with suicide.**
b) **Murder**
c) **Accidental due to mismanagement of prescribed medication by patients**
d) **Inappropriate prescribing by physician**
e) **Incorrect dispensing by the pharmacy**
f) **Taking larger dose than usual of a drug bought on the street**
g) **Taking drugs bought on the street that are laced with other drugs**

I gather that we are trying to deal with (c)
I am not all sure that moving T2s and T3s to M3P is going to solve any of the issues that have been raised. They will still be prescribed, and accidents and misuse will still occur.
On the other hand, it may well have a several negative effects.

1. **The danger is that a number of physicians will stop prescribing these medications which have been very useful for occasional use.**
2. **The patients maybe switched to other medications which need to be taken on a daily basis so increasing polypharmacy.**
3. **There are a number of patients that are unable to take NSAIDs for a number of reasons. Tylenol is a help but only so far and again in some patients is contraindicated. With moving these medications to M3P it can gives the impression to patients that T2s & T3s are equally as dangerous as the other restricted drugs on M3P and they may well refuse them and deny themselves some relief from pain.**

I graduated from Medical School in 1963 and at present am semiretired. In all these years, to the best of my knowledge I have never had anyone become addicted to any medication I have prescribed. Initially, I practiced as a family practitioner along with my husband in a small rural hospital, looking after anything that came through the doors. But for over 30 years most of my

practice has been looking after Fibromyalgia & Chronic Pain patients. A number of patients refer themselves to me and others are referred by physicians and NPs. I recommend very few drugs, but I do prescribe small amounts of T3s occasionally. Usually, 15 tabs and sometimes with 1 repeat in a month's time. In fact, during this time I have never prescribed any other opioids. I find that so many patients have been prescribed continuous medications such as Duloxetine, Pregabalin, Gabapentin etc., and still are in pain. These medications have many serious side effects, and some patients abruptly stop the medications so causing even more issues. These are also medications I do not prescribe. Many patients turn to self-medicating with Marijuana and alcohol, still are in pain but now with even more problems, and some with tragic results.

In conclusion, I believe this is an extremely difficult problem, and I do understand that these drugs should be better regulated. I hate to see a patient who is regularly taking 8 tabs of T3s a day and has been for ages. I think this is where there better management at the pharmacy level of only being able to dispense 15 tabs at a time might be much more useful.

Respectfully submitted:

ADDENDUM 3

College of Pharmacists of Manitoba

200 Tache Avenue, Winnipeg, Manitoba R2H 1A7
Phone (204) 233-1411 | Fax: (204) 237-3468
E-mail: info@cphm.ca | Website: www.cphm.ca

February 14, 2025

The College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg, MB R3J 3Y7
Via email: CPSMconsultation@cpsm.mb.ca

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

Thank you for the opportunity to provide feedback regarding the proposed addition of non-exempted codeine products to the Manitoba Prescribing Practices Program (M3P).

The opioid crisis in Canada is a well-documented public health concern, with the misuse and diversion of codeine being significant contributing factors. A prevailing misconception among healthcare professionals is that codeine is a “less potent” opioid, likely due to its relatively less stringent provincial prescribing requirements. However, data from the Manitoba Office of the Chief Medical Examiner consistently identify codeine as one of the most frequently implicated opioids in overdose deaths in Manitoba.

After careful consideration of the evidence, the College of Pharmacists of Manitoba (CPhM) Council has approved the inclusion of all non-exempted codeine products in the M3P schedule at their September 2024 meeting. As outlined in section 76 of the Pharmaceutical Regulation, any additions or amendments to the M3P schedule require joint approval by both the CPhM and CPSM Councils. Accordingly, CPhM Council strongly encourages the CPSM Council to approve these additions to enhance prescribing safety and safeguard the health of Manitobans.

Thank you once again for considering this feedback. Should you have any questions or require further information, please do not hesitate to reach out.

Kind Regards,
Sent on behalf-of CPhM

[redacted]

COUNCIL MEETING – MARCH 19, 2025

FOR INFORMATION BRIEFING NOTE

SUBJECT: IMG Working Group Update

BACKGROUND:

Since the last update, the IMG Working Group met on December 10, 2024, and February 4, 2025.

Participants addressed:

- 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 working group's discussions underscored the urgent need for systemic change and enhanced support within the medical community.

At its last meeting, the IMG Work Group approved survey content, which has been referred to CPSM's IT Department to develop an online version for registrants to complete. It is hoped this will be sent out in March of 2025.

The Working Group has also made significant progress on deciding components for the orientation program and for the Standard of Practice. The goal is for a draft Standard of Practice to be provided to Council for consideration in September of 2025. The curriculum for the orientation program should also be established by that time. The survey results will be crucial in finalizing these deliverables.

COUNCIL MEETING - MARCH 19, 2025

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Amendment to Council Policy – Registration in Provisional Specialty Practice-Limited, Assessment Candidate Speciality Practice, and Provisional Non-Practicing Classes – adding PRA Exemption

BACKGROUND:

The Royal College of Physicians and Surgeons of Canada (RCPSC) has created a certification pathway for internationally trained specialists with significant clinical experience without the necessity of completing a RCPSC-accredited residency program in Canada. This Practice Eligibility Route (PER) allows experienced specialists to obtain RCPSC certification after demonstrating competency through a combination of assessment, examination, and Canadian practice experience.

The proposed amendment to the Council Policy would permit the PER to be an acceptable exception for these specialists having to undergo a Practice Readiness Assessment (PRA) when specific criteria are met to the satisfaction of the Registrar.

To obtain RCPSC certification via the PER, candidates must:

- Have completed specialist training outside of Canada that is not accredited but is recognized by the RCPSC.
- Have at least five years of independent, unsupervised clinical practice in their specialty in a jurisdiction where they were licensed to practice.
- Submit a portfolio for assessment, including proof of education, training, clinical experience, and practice patterns.
- Pass the RCPSC certification exam in their specialty.
- Have at least two years practice experience in the specialty field in Canada.

Once successful, the physician becomes certified by the RCPSC.

Candidates can become eligible for certification via the PER based on an RCPSC evaluation of training and experience.

It is important to note, candidates can take the certification exam before practicing in Canada. Therefore, there are PER candidates who have successfully completed the exam, but who will not obtain RCPSC certification until they have completed two years of practice experience in Canada.

Several Canadian MRAs do not have a PRA requirement for physicians who are eligible for RCPSC certification via the PER.

- CPSNS essentially provides full registration upon completion of the RCPSC certification examination.
- CPSBC has no PRA option and permits provisional registration upon completion of the RCPSC certification examination.
- CPSA requires a PRA.
- CPSS, CPSPEI, and CPSNL have no PRA and permits provisional registration upon completion of the RCPSC certification examination.
- CPSO has no PRA and permits restricted registration upon completion of the RCPSC certification examination.

While not a determinative circumstance given our overriding public protection mandate, Manitoba's current practice puts it a disadvantage for recruiting ITPs. The PRA program has limited spots, requires sponsorship, and is expensive. ITPs will often go to other jurisdictions with less stringent requirements.

It is recognized that the PRA assesses whether a physician understands the Canadian healthcare protocols, cultural expectations, and interdisciplinary collaboration. This is important for an ITP who has not practiced in Canada. However, CPSM needs to consider whether concerns about waving the PRA can be mitigated through support, orientation, mentorship, and supervision requirements. To that end, it is proposed to add the following to the Policy **(*Appendix A*)**:

> ***3.6*** *Pursuant to subsection* ***3.16(2)(e)****, an applicant is exempt from having to undergo an Approved Assessment if they have obtained eligibility for Royal College certification through the practice eligibility route and*
>
> - *have successfully completed the certification examination,*
> - *agree and undertake to complete an orientation plan satisfactory to the Registrar, and*
> - *establish that their practice endorses waving the PRA requirement and will provide satisfactory mentorship and support during their transition into the Manitoba Practice Environment.*
>
> *Meeting the last criteria will generally require support from the provincial specialty lead.*

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 19, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

> Council Policy – Registration in Provisional Specialty Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes be amended by adding the above at section **3.6**.

COUNCIL POLICY

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

Initial Approval: December 18, 2024 **Effective Date: December 18, 2024**

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3. Provisional (non-practicing) class 13

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. <u>Cancellation</u>

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.

COUNCIL MEETING M- MARCH 19, 2025
FOR INFORMATION BRIEFING NOTE

SUBJECT: Registrar/CEO's Report

Internal - People and Culture

- In an effort to more effectively manage growth and align resources with priorities to keep up with CPSM's progress in the past few years, the following two changes were made to the leadership team.
    - In February, Sherry Dupuis transitioned into the role Executive Director, People & Culture. She previously held a consulting role; a more permanent role and increased time commitment will allow her to focus on key HR areas.
    - Also in February, Paul Penner's title was updated to Chief Financial Officer (formerly Chief Operating Officer) to better reflect his duties and responsibilities. CPSM's complexity and organizational growth requires increased attention to risk management, business continuity, infrastructure management and emergency preparedness. The redistribution of HR duties opened up this opportunity for better alignment.
- The senior leadership team went through an organizational risk identification exercise. A risk registry was provided to the Finance, Audit, and Risk Management Committee.
- The senior leaders meet regularly to monitor progress on organizational priorities, identify, and address emerging challenges.

External Relations

- Hosted the Honourable Uzoma Asagwara, Minister of Health, Seniors, and Long-Term Care for a meeting with Council and the senior leadership team. We provided an update on progress toward Truth and Reconciliation in medical regulation, shared regulatory priorities, and discussed common goals and opportunities for better alignment.
- Met with Aboriginal Health & Wellness and Keewatinohk Inniniw Minoayawin Inc. (KIM).
- Met with Ndinawemaaganag Endaawaad Inc. (Ndinawe) along with Dr. Lisa Monkman to hear feedback and concerns regarding the Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism CPSM's commitment to anti-Indigenous racism in medical care.

- 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.

- Delivered a lecture at *Fridays at the University* CPD event on the topic of Understanding Self-Regulation.

- Delivered a lecture on Professional Self-Regulation to medical students in the Health Law med 1 course.

- Initiated pre-consultations on collaborative care with various stakeholders.

COUNCIL MEETING - MARCH 19, 2025

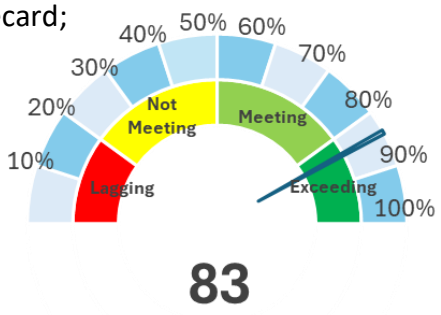
FOR INFORMATION BRIEFING NOTE

SUBJECT: Performance Metrics Reporting

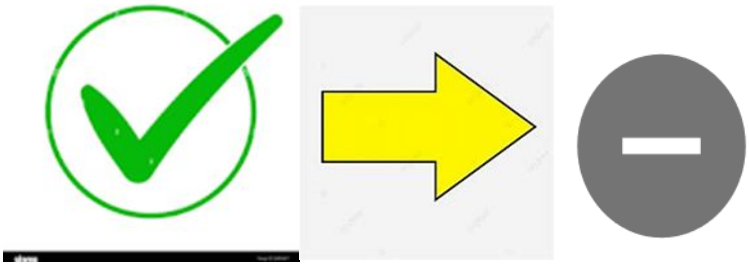
BACKGROUND:

The 3rd quarter 2024/25 performance metrics reporting scorecard is attached for Council's review. The new report's first section summarizes each area and relative performance. The remaining sections of the scorecard highlight each area and use graphics to represent how the specific metric is performing.

Metrics are presented in 4 distinct ways on the attached scorecard;



- A speedometer which indicates the performance of the metric,
- Or a green check mark (on track), yellow arrow (not meeting) or a greyed-out circle (information not available) for metrics that don't lend themselves well to a speedometer graphic.



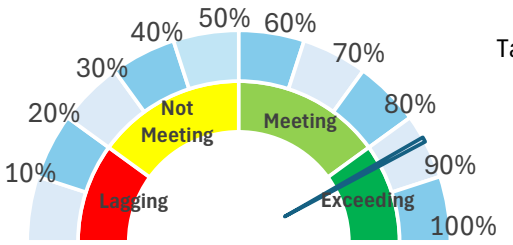
Below the graphic is a description of the performance indicator, the target(s) and where applicable, the variance explanation/course correction for performance indicators that are not on target.

The 2024/25 3rd quarter scorecard includes all areas of CPSM including, Complaints and Investigation and Registration. Our hope is the graphical representation will more effectively and clearly communicate CPSM's performance metrics.

CPSM Performance Scorecard

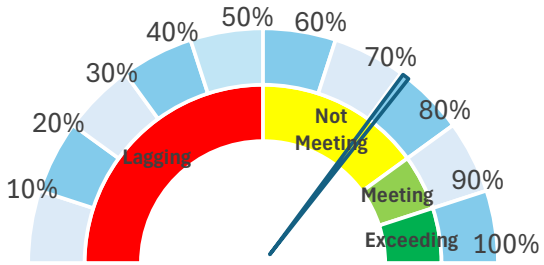
	Snapshot				
	Quality	**CI**	**Registration**	**Support**	**Total**
Meeting/Exceeding	7	1	2	8	18
Not Meeting	5			3	8
Lagging		**1**			
Insufficient data	1		1		2
Total # of Performance Metrics	13	2	3	11	29

QUALITY - Quality Assurance

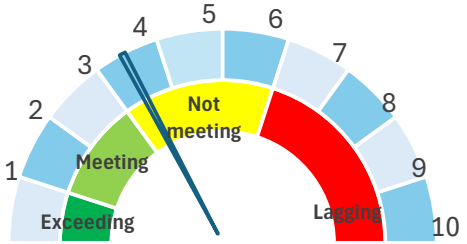


Target

83



71

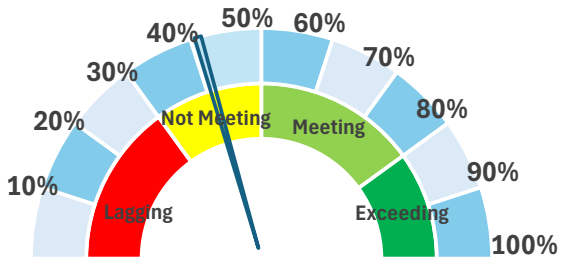


3.5

Q1 & Q2 had 96% of audits performed within 30 days

Perfomance Indicator	Registrants will demonstrate a measurable improvement on follow-up assessments*	Audits will be performed a timely and predictable manner	Provisional Registration chart audit reports will be sent to the physician in a timely and predictable manner
Targets	Target is 50%	Target is 80% within 30 days	Target is 3 days
Variance Explanation/Course Correction		Issues with Auditor availability during the 3rd Quarter saw 0/9 audits performed within 30 days. Will be reviewing to redistribute audits away from major holidays	Process has been updated and target should be met going forward

QUALITY - Physician Health



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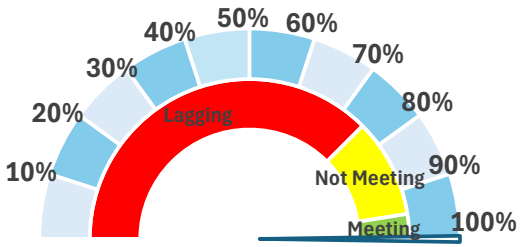
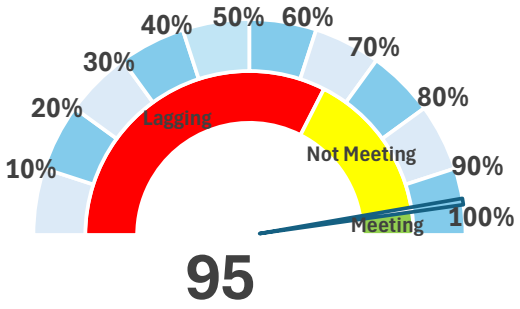


100

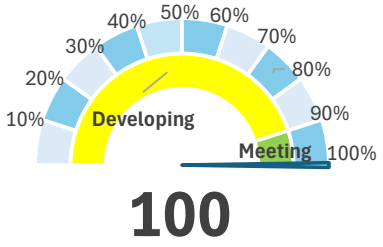
Perfomance Indicator	# of referrals coming from registrants about self/colleagues to the PHP	Implement the necessary monitoring/restrictions on identified high-risk registrants.
Targets	50% generated from self referrals	100% of flagged registrants are monitored
Variance Explanation/Course Correction	Uptick in UGME referrals this quarter. Will continue to monitor and reassess targets once 2 years of data is accumulated	

QUALITY - Quality Improvement

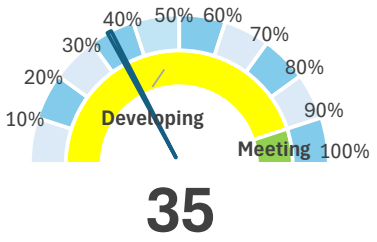


Quality Improvement is on track to "initiate" reviews with 100% eligible registrants by Dec 2025.

Category 1



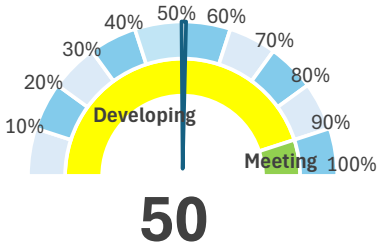
Category 2



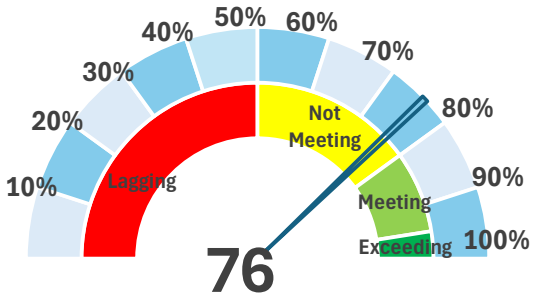
Perfomance Indicator	CPSM will complete reviews of 95% of all eligible registrants by the end of the seven year cycle (December 2025)
Targets	Complete 19% of registrants/year

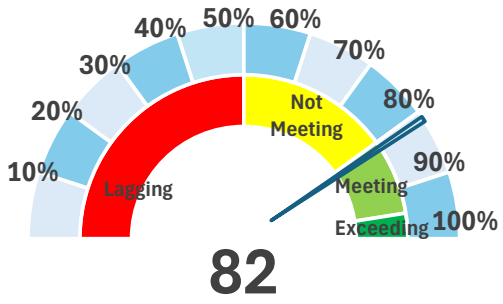
QI process will be completed within targeted timelines 90% of the time for Category 1 (30 days), 2 OCR (110 days) and 3 (240 days)	
90% completion: Category 1 -30 days	
	Category 2 - 110 days
	Category 3 - 240 days

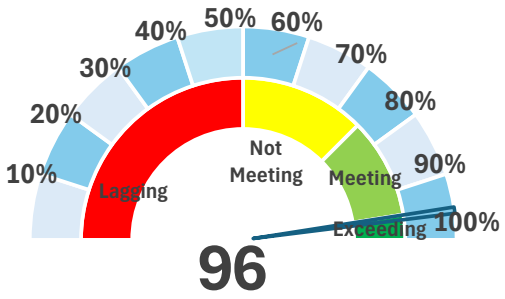
Category 3



QUALITY - Prescribing Practices Program





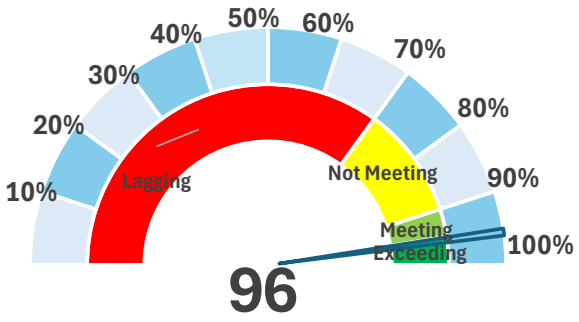


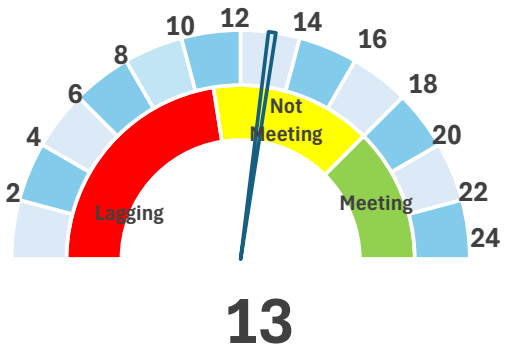
76% within 1 business day
87% withing 2 business days

82% high risk within 1-2 business days
100 % moderate within 1-2 weeks

Perfomance Indicator	Will respond in a timely manner to general prescrbing advice inquiries	PPP will provide timely intervention for general prescribing advice inquiries with significant risks identified	PPP will provide timely intervention for general prescribing advice inquiries with significant risks identified
Targets	80% - 1 business day 90% - 2 business days	80% of high risk cases responded to in 1-2 business days 80% of moderate risk in 1-2 weeks	75% of surveys will rate impact of interventions as neutral to positive
Variance Explanation/Course Correction	January saw a steep rise in GPA cases. PPP prioritized responses which resulted in 54% contacted same day (less than 1 business day).		

QUALITY - Accreditation

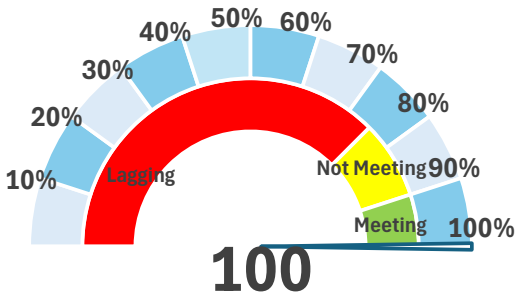




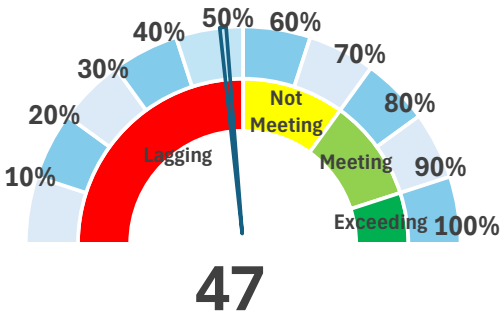
due to external factors, this measure is on hold

Perfomance Indicator	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	MANQAP completion of 24 temporary status site accreditations accumulated since Covid to meet compliance with the Continuing Service Agreement MB	Monitor and measure MANQAP implementation of the new WCAA Laboratory and Transfusion Medicine rollout.
Targets	90% of inspections completed	2 inspections/month	Inspect 40 sites over a 4 year cycle
Variance Explanation/Course Correction		Issues with respect to coordinating inpsectors and site visits. Expect to have 3 sites remaining by the end of the 4th quarter that will need visits.	

COMPLAINTS & INVESTIGATIONS



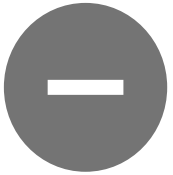
1/1 case



32% as of June 30, 2024

Perfomance Indicator	Response Time for Boundary Violations/Severe Care Issues	Responding to Complaints and Informal Resolution in a Timely Manner	Further Metrics Under Development
Targets	90% have plans in place in 5 days	80% of cases resolved in 180 days	
Variance Explanation/Course Correction		New processes still in implementation phase. Continuing to revamp processes and the use of quality auditors to clear the backlog	

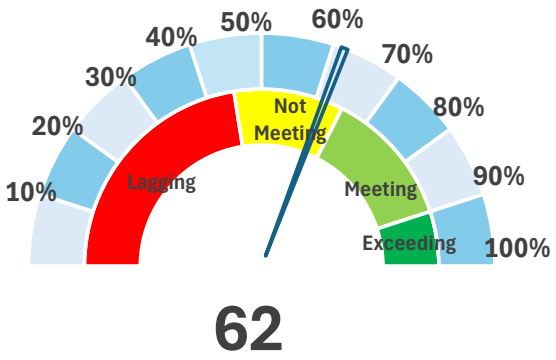
REGISTRATION



*Avg time to respond to applicant - 2 days
*Avg time to advise re eligibility - 3 days
*Avg time for applicant to complete appliation - 7 days
*Avg # of days applications are "open" - 41 days

Perfomance Indicator	National Registry Project development and implementation		Compliance with Fair Registraiton Practices Office	Applications processed in a timely way.
Targets	Implementation of Phase 2		Ensure adoption/compliance and timely reporting	Currently reviewing data

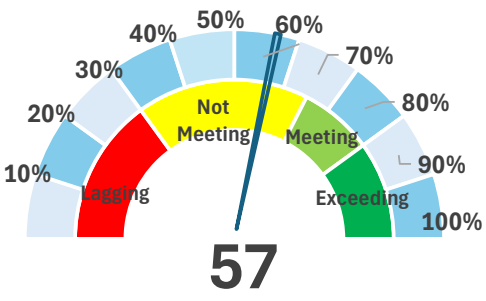
SUPPORT AREAS - Finance

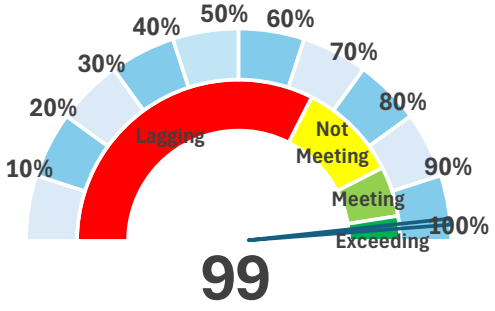


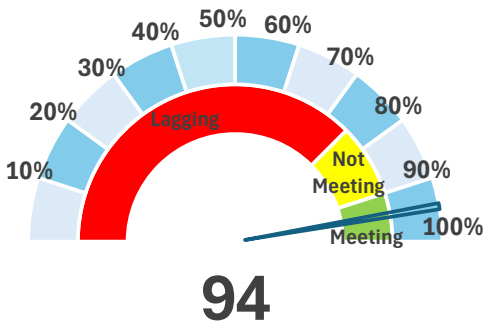
CPSM on track for a balanced budget in 2024-25

Perfomance Indicator	CPSM will maintain adequate reserves	CPSM will achieve a balanced budget
Targets	Debt to Equity ratio of 0.7 (reported annually) Reserves are maintained at a min of 66% of annual operating expenses	
Variance Explanation/Course Correction	Plan to review at year-end, CPSM still maintaining adequate reserves in the event of major disruptions	

SUPPORT AREAS - Information Technology





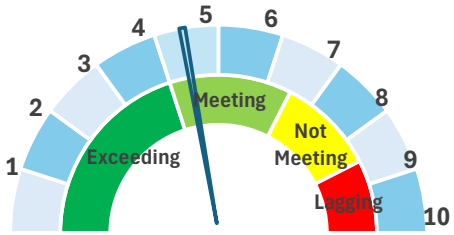


Perfomance Indicator	CPSM's technology and information is protected from both external and internal loss/destruction	Information Systems are considered highly reliable and available	IT responsiveness
Targets	Centre for Internet score of 65% or 3.25/5	Target is under development	Triage IT issues - 95% within 24 hours
Variance Explanation/Course Correction	On track for meeting the target of 65 by year-end		

SUPPORT AREAS - People & Culture

Average YOS - 8.3

0 resignations since last report
(1 resignation from May 2024 to January 2025)

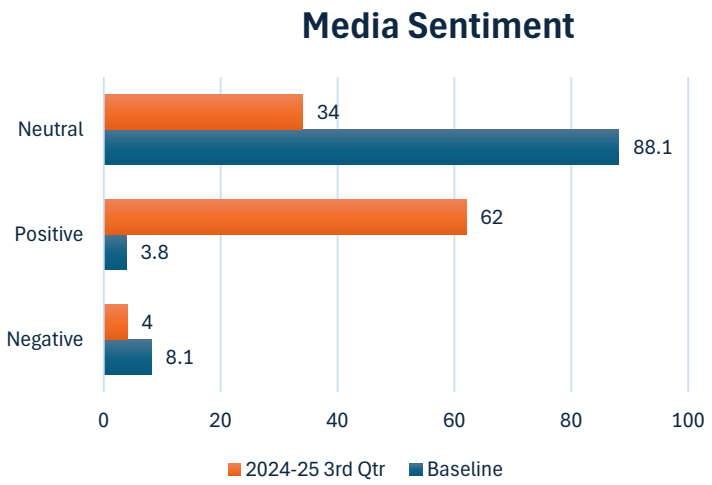


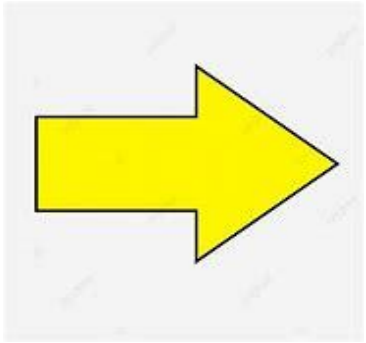
4.53

Average sick time was 6.6 days in 2023
Average sick time was 6.3 days in 2024

Perfomance Indicator	Employee satisfaction and engagement with CPSM priorities	Retention of staff	Employees are productive
Targets	Conduct staff Survey and report on findings	1. Average years of service 2. # of Employees resigning	Public Sector benchmark - 13.4 days sick Private Sector benchmark - 7.5 days sick

SUPPORT AREAS - Communications





Perfomance Indicator	Increase positive sentiment score in media coverage	# of educational opportunities executed	# of engagement targets met
Targets	Improve sentiment by 20%	Improve public education of CPSM core mandate	Boost engagement from public & registrants
Variance Explanation/Course Correction			Focus has been on internal communications and registrant communications this last quarter. Will be seeking more opportunities for public engagement

COUNCIL MEETING - MARCH 19, 2025

FOR INFORMATION

SUBJECT: Operational Reports

STAFF MATTERS

The information below summarizes the staffing changes and additions that occurred post the December 18, 2024 Council meeting.

Quality Department

Dr. Liesel Möller has accept the position of Medical Consultant (0.6 EFT) with the Quality Department effective January 13, 2025.

Recruitment is nearing completion for the new Restorative Practices Program staff (Medical Consultant and support staff)

Senior Leadership

CPSM has experienced significant change and growth over the last 4 years. To more effectively align leadership with CPSM priorities the following changes have been made.

Ms. Sherry Dupuis has increased her commitment to CPSM, originally 0.2 EFT as CPSM's Human Resources Consultant, to Executive Director, People and Culture (0.6 EFT). This change is effective February 18, 2025. Ms. Dupuis will be reporting directly to the Registrar. Up to this point Mr. Paul Penner has taken on many of the human resources duties under the Chief Operating Officer role. With the appointment of Ms. Dupuis to Executive Director, People and Culture, it was important to redefine Mr. Penner's role. Effective immediately Mr. Penner will be retitled to Chief Financial Officer.

COMMUNICATIONS & MEDIA

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

Public/Stakeholder Engagement

- Managed the communications components of the public consultation on the addition of non-exempted codeine products to the Manitoba Prescribing Practices Program (M3P) and amendment to Practice Direction - Professional Practice and Inactivity.

- Developed a plan and collateral for pre-consultation of the Standard of Practice - Collaborative Care.
- Contributed to and finalized survey to be distributed to registrants to inform outcomes by the IMG Working Group.
- Oversaw CPSM sponsorship of two events.
- Responded to several media inquiries where they aligned with regulatory matters. Media coverage in this period included inquiries regarding registration data, Dr. Daljit Singh Gill suspension, questions regarding CPSM's role in responding to anti-Indigenous racism in medical care and mandatory Indigenous cultural safety training.

Registrant Communication Campaigns

- Medical Consultant opportunity (Prescribing Practices Program).
- Public Consultation Notice for the addition of non-exempted codeine products to the Manitoba Prescribing Practices Program (M3P) and amendment to Practice Direction - Professional Practice and Inactivity.
- December newsletter – topics included: Key Takeaways from the Practice Direction for Professional Practice and Inactivity, changes to liposuction standards, Clarification on the use of titles for Clinical Assistants, Bylaw Amendment impacting Anesthesiologists working in dental surgery clinics.
- December Council Update.
- New Assistant Registrar for Quality announcement.
- Medical consultant opportunity (Restorative Practices Program).

FINANCE

Year to date financial results

For the period ending January 31, 2025, CPSM has posted a net surplus of $397,446 vis-à-vis budgeted deficit of ($671,996). The improved financial position is primarily due to lower than expected inquiry costs, better than anticipated revenue as well as cost savings driven by unfilled position staff savings.

Implementation of Electronic Funds Transfer

The final phase involving honoraria recipients is rolling out successfully.

INFORMATION TECHNOLOGY

The IT Team successfully implemented some enhancements through the CPSM Portal.

- A new reporting system was implemented that allows the University of Manitoba Rady Faculty of Medicine to review reports on applicants entering medical school that includes real-time updates.

- In collaboration with Doctors Manitoba, an improved and more effective reporting system was implemented indicating changes to our registrant membership base on a weekly basis.

The IT Team continues to work on the projects listed in the previous updates;

- IMG Working Group survey
- Quality Assurance digital platform
- Accreditation team digital platform
- CPC updates (workflow and form updates)
- Cybersecurity updates
- National Registry Project

QUALITY DEPARTMENT

Physician Health Program (PHP)

- From December 18, 2024 to February 18, 2025, the PHP received 12 new referrals. 9 of these referrals remain open for follow-up and further PHP involvement.
- Since the start of the fiscal year (May 1), we have had 86 new referrals (compared to 76 new referrals from same time last fiscal year)
- We have 45 current undertakings, with one more pending signature.
- **PHP caseload is: 133 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).
- PHP will be presenting to the PGME Program Directors and Administrators RE: Medical LOAs and our process. The goal is to improve communication between PGME and CPSM Registration and PHP, and to streamline the process of return from medical LOA for PGME registrants.
- Currently conducting a review of the best SUD monitoring modalities. Based on current information, there is a high likelihood PHP will recommend changes to all applicable undertakings to come with the goal of more complete and randomized monitoring and easier access for registrants.
- Ongoing review of BBP Undertakings.

Quality Assurance Program (QAP)

- Total potential reviews up until June 2025 is **92.**
- Currently there are 92 open files in various stages of the process:
    - Waiting for Questionnaire - 48
    - Waiting for Manitoba Health - 4
    - Review Scheduled – 6
    - Going to March CSC – 13
    - Difficult to Review Process – 21
- The 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
- Currently working on cohorts 71 and 70 years of age including a marginal number of carry-overs from 2024.
- The CSC reviewed a total of 101 registrants between January - December 2024.
- Moving the QAP to portal is currently being implemented.

Quality Improvement Program (QIP)

- Dr. Liesel Möller, 0.60 FTE Medical Consultant, joined QIP on Jan 13, 2025.
- CI backlog case reviews near completion.
- Work plan in process to meet the end of the first cycle which ends in December 2025.
- Planning underway for program adjustments for second cycle 2026-2032.

Prescribing Practices Program (PPP)

- **Registrant Advice & Support**: responded to **45 general prescribing advice** inquires Dec-Feb (**37** GPA cases thus far in 2025). KPI metrics: 53% responded to same day, 76% within 1 business day, and 82% within 2 business days.
- **Outcome Evaluation**: Since March 2024, 57% response rate for (anonymous) surveys sent registrants/other HCPs who seek prescribing advice, to evaluate the impact of PPP interventions. 100% of surveys rated the overall impact of PPP interventions as neutral to positive on a Likert scale. 96% of responses rated the impact of PPP interventions as positive (i.e., ≥ 4, agree to strongly agree).
- **Prescribing Approvals**: Issued **8 Suboxone** & **2 methadone approvals** for OAT Dec-Feb (current total 242 OAT prescribers). 1 pending pain/palliative methadone approval for Feb (current total 70 P&P prescribers).
- **Quality Prescribing Review Working Group**: Responded to 25 inquires related to prescribing rules changes since effective June 1, 2024. 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 review process and initial work started with 4 registrants. Risk stratification is 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 approved.
- Diagnostic Standards to be presented before April PRC meeting for approval to implement new WCAA DI standards. New standards to be introduced to all DI sites through communication strategy in the Spring of 2025 with the first accreditation inspections implemented end of 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 2024, opening inspection scheduled March 2025.
- Psychedelic Assisted Psychotherapy standards will be presented for approval to PRC after February meeting 1st accreditation to take place in early spring 2025.
- Pre inspection site visit completed for NHMSF Prairie Surgical- accreditation opening pending outstanding citations, Conditional to open accreditation for scopes was granted in December 2024. Another opening inspection for Plastics, Dental and Urology procedures to take place end of Feb 2025.
- Finalizing survey questions to evaluate implementation of WCAA Laboratory standards. Survey to be distributed as sites are granted full accreditation.
- MANQAP continues to work with IC and Quality on investigation and complaints.
- APO submissions reached 59 for 2024 compared to 25 in 2023. As of 18 February 2025, two received in 2025. Active cases 40.
- HR Callie Farthing continues to support MANQAP on contract as temporary FTE until July 30, 2025.

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The C&I department continues its work on process review. This review is starting to generate more concrete process changes that will be visible to Registrants and the public in the next 6-12 months. These include:

Development of a new triaging process for records requests or issues with referrals/forms being completed. These will be handled through courtesy phone calls unless a pattern of issues is identified. In the case of a pattern being detected, internal referral to Quality for review will be the first remedial step. Only in instances where Registrants are persistently failing to respond to requests and do not improve following Quality review will C&I become formally involved. This should reduce burden on C&I for one-off issues and enable faster service to members of the public.

Resolution time for the various types of complaints is beginning to improve, although a long road ahead remains. For Resolution by Communication, resolution under 180 days was 61% in 2023, and improved to 68% in 2024. For Complaints Committee matters, resolution under 180 days was 7% in 2023, which more than doubled to 18% in 2024. Most notably, Complaints Committee matters received after August 2024 have had a resolution time, on average, of 112 days thanks to improved processes championed by our Complaints Committee Medical Consultants.

Investigation Committee matters are largely unchanged, with 20% being resolved under 180 days in both 2023 and 2024. Given the increased complexity of IC matters, C&I is still working through what appropriate targets would represent. In the interim, a much more outcome-focused measure is being proposed. Specifically, time-to-implementation of mitigation measures once a serious boundary or care issue is identified will be implemented moving forward.

REGISTRATION DEPARTMENT

The primary role of the Registration Department is to ensure that only qualified, competent, and ethical applicants are granted registration and issued a certificate of practice in Manitoba. In addition, the Department has been in a process of re-imaging its role and purpose to include:

- achieving better access for the people of Manitoba to adequate numbers of qualified and competent medical practitioners,
- establishing and maintaining clear information about registration requirements,
- promoting the ability of members to respond to changes in practice environments, advances in technology and other emerging issues, including by establishing new and improved orientation initiatives, and
- promoting and enhancing CPSM's relations with registrants, other regulatory colleges in the province, as well as key partners and the public.

To meet the above objectives:

- The Registration Department will develop new Key Performance Indicators and Key Risk Indicators, as well as a comprehensive Quality Management System to better track our work and ensure an evidence-based approach to efficiently achieving CPSM's mandate. Fundamental to this work is first establishing an improved infrastructure for reporting data, as well as a data and reporting strategy.
- Review and updating of the Registration section of the website continues. The focus is on step-by-step information for all classes of registration, with further wording modifications targeting accessibility to come. CPSM is also collaborating with partners with Shared Health and the Health Care Retention and Recruitment Office (HCRRO) to improve information and communication relating to our more complex processes.
- 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 provisional registration of family physicians and specialists.
- We are committed to having a strong relationship with Manitoba's Fair Registration Practices Office (FRPO), including by meeting the FRPO's Duty to Notify and Duty to Collaborate. The FRPO provides invaluable insight and recommendations for improving registration processes.
- Supporting the development of the National Registry of Physicians through collaboration with the MCC and other Canadian MRAs.
- Staying abreast of national and global changes in the registration and licensing of medical practitioners to ensure CPSM is implementing best practices, including through our relationship with FMRAC (Federation of Medical Regulatory Authorities of Canada) and IAMRA (Internation Association of Medical Regulatory Authorities).
- Supporting the work of the IMG Working Group, including its goal of establishing a new orientation program for Internationally Trained Physicians.
- The Board of Assessors had its third meeting in February of 2025. It is supported in its work by staff in the registration department.

Significant projects for the year to come include:

- a review and revisions to CPSM's license renewal questions,
- a review of how we regulate medical corporations permits, and
- Implementing improvements to the PRA process.

COUNCIL MEETING - MARCH 19, 2025
COMMITTEE REPORTS
FOR INFORMATION BRIEFING NOTE

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met on February 26, 2025, most of the matters discussed at the meeting appear on this Council Agenda.

The Executive Committee met as a Panel on January 15, 2025, pursuant to section **110(2)** of the *RHPA* to hear an Appeal of Interim Conditions imposed by the Chair of the Investigation Committee.

The Executive Committee met as a Panel on February 26, 2025, pursuant to section **50** of the *RHPA* to hear a Reinstatement Application.

The Executive Committee held Appeal Panels on March 7, 2025, in which 6 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:

1. **Year to date financial report – to January 31, 2025**
   - Management presented the year-to-date results as well as a revised forecast. January 31, 2025 results show a surplus of approximately $400,000. The original forecast predicted a deficit of approximately ($670,000). The change is predominantly due to the following factors;
     - Inquiry expenses significantly below the original forecast
     - Temporary staffing savings
     - Increases in revenue

   - The financial forecast for 2024-25 has been updated to a surplus of $150,000 at year-end from the originally forecasted deficit of $977,000.

2. **Council Policy – Financial Management**
   - Management completed an environmental scan of our partner MRA's across the country with respect to risk level and their investment strategy. Management also received feedback regarding formal policies in other MRA's that prohibit the ownership or purchasing of land/buildings. Only CPSM specifically states this prohibition in policy. The findings were shared with the committee with potential language in the Financial Management policy that would update CPSM's investment risk tolerance going forward.

The Committee requested management meet with our current investment advisors to provide a revised draft.

3. **Risk Management**
   - Management presented a risk registry for comment and review. The risk registry was developed as a complimentary tool to the FMRAC Integrated Risk Management program. As per the CPSM Risk Management Policy a risk register should be compiled along with mitigation measures. The risk registry will be presented to Council in the near future.
   - A cybersecurity incident response plan was presented to the Committee. CPSM Management is planning on a table-top exercise to "stress" test the incident management plan.
   - The Committee requested management to explore training opportunities on risk for both the Committee as well as Council.

Respectfully submitted by
Dr. Charles Penner
Chair, Audit & Risk Management Committee

INVESTIGATION COMMITTEE REPORT:

The Investigation Committee has met three times since my last report (December 11, January 15 and February 12). We reviewed 31 cases in those meetings.

The results include:

- No further action = 20
- Letter of Advice = 5
- Letter of Criticism = 2
- Undertaking for Education = 3
- Deferred = 1

As of now, there are 165 outstanding Investigations.

Respectfully submitted by
Dr. Kevin Convery
Chair, Investigation Committee

COMPLAINTS COMMITTEE REPORT:

The Panels of the Complaints Committee have met eight times since May 1, 2024:

- May 9, 2024
- June 6, 2024
- September 12, 2024
- October 10, 2024
- November 21, 2024
- December 5, 2024
- January 9, 2025
- February 6, 2025

During this period, 125 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 January 9, 2025		**For the year** May 1, 2023 to Apr 30, 2024	
No further action	**61**	49%	77	52%
Advice	**29**	23%	43	29%
Criticism	**15**	12%	18	12%
Informal resolution	**3**	3%	1	1%
Referral to Investigations Committee	**9**	7%	4	3%
Cases withdrawn	**4**	3%	5	3%
Dismissed	**1**	1%		
Referred to Quality Improvement Program	3	2%		
Total	**125**	**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 eight-month period is compared with the previous 2023 – 2024 full year.

Cases closed during the period	**For the period** May 1, 2024 to February 6, 2025 (8 months)	**For the year** May 1, 2023 to Apr 30, 2024
Number of meetings	**8**	**11**
Outstanding cases, beginning of year	134	119
New complaints received during period	114	163
Total number of complaints	248	282
Outstanding cases, end of the period	123	134
Total cases closed during period	**125**	**148**

Respectfully submitted by
Ms. Lynette Magnus
Chair, Complaints Committee

PROGRAM REVIEW COMMITTEE REPORT:

Diagnostic Facilities:

With the addition of new staff, MANQAP has been able to focus on decreasing the number of sites that were given temporary accreditation due to the COVID-19 pandemic.

The Table below compares the number of facilities with temporary accreditation (blue columns) in February of this year with March of last year. It also shows the total number of public and private facilities who require MANQAP Diagnostics Accreditation (orange columns).

	February 2025		March 2024	
Discipline/Modality	# with Temporary Accreditation	Total # of Facilities	# with Temporary Accreditation	Total # of Facilities
Radiology	9*	94	26	92
Ultrasound	6	29	8	29
Computed Tomography	2	17	6	16
MRI	1	9	4	10
Non-Radiologist Fluoroscopy	1	19	6	18
Laboratory	4	75	17	76
Transfusion Medicine (TM)	4*	53	11	53
Patient Service Centre (PSC)	10 *	44	6	45

One TM, five PSC, and five Radiology facilities with temporary accreditation have an inspection scheduled before the end of March 2025.

Non-Hospital Medical Surgical Facilities (NHMSF):

The NHMSF Adverse Patient Outcome (APO) process continues to evolve as education with the sites is provided via inspections and feedback/follow up from the APO reviews.

59 APOs were reported in 2024 (1 January 2024 to 31 December 2024), compared to 25 in 2023 (1 January 2023 to 31 December 2023).

Additional staffing has enabled data entry of the APO forms to occur, which will facilitate the monitoring of trends. MANQAP has begun to look at the data.

Respectfully submitted by
Ms. Leanne Penny
Chair, Program Review Committee

BOARD OF ASSESSORS REPORT:

The Board of Assessors met on February 13, 2025. Three policies were reviewed and endorsed by the Board with some modifications:

- the first for registration in the Family Practice-Limited Class,
- the second for registration in the Specialty-Limited class, and
- the third for English Language Proficiency.

The Board also considered proposed amendments to the CPSM General Regulation relating to eligibility requirements for the provisional registration of family physicians. The foregoing issues all appears on Council's agenda. The Board also considered two (2) applications 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, September 13, and December 13, 2024.

QUALITY ASSURANCE (QA) AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2023

The CSC reviewed:

- 44 New and Repeat QA Age Triggered Reviews
- 47 New and Repeat QA Referred Reviews

The following outcomes were determined at CSC.

*57	#1 Outcomes (*Multiple doctors from one review three total)
*28	#2 Outcomes (*Multiple doctors from one review one total)
12	#3 Outcomes
4	#4 Outcomes
*2	#5 Outcomes (Multiple outcomes from one review)
2	Other – Full Practice Audit, Interactive Audit and More Information Requested
105	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 and annual reports from the various Standards Committees within the province. The following table represents the active committees by region and status.

Current active Committees by Region:

Committee	RHA	Chair	Current Status
Brandon Regional Health Centre ASC	Prairie Mountain	Dr. Brian Bookatz	Up to date
Interlake-Eastern ASC	Interlake-Eastern	Dr. Habtu Demsas	Up to date
Northern ASC	Northern	Dr. Shadi Mahmoud	Up to date
Portage ASC	Southern	Dr. Jim Ross	Up to date
Prairie Mountain Health ASC	Prairie Mountain	Dr. Shannon Prud'homme	Up to date
Southern ASC	Southern	Dr. Shayne Reitmeier	Up to date
Boundary Trails Health Centre	Southern	Dr. Kevin Convery	Up to date
C.W. Wiebe Medical Centre	Southern	Dr. Louw Greyling	Annual report reminder sent Jan 7
Eden Mental Health Centre	Southern	Dr. William Miller	Up to date
CancerCare	Provincial	Dr. Chantalle Menard	Up to date
Endoscopy Provincial	Provincial	Dr. Ross Stimpson	Up to date
Orthopedic Surgery Provincial	Provincial	Dr. Eric Bohm	Annual report reminder sent Jan 7
Winnipeg Regional Health Standards Committee	WRHA	Dr. Elizabeth Salamon	Annual report reminder sent Jan 7

Cumulative Reporting by Area/Region

The following cumulative report includes total numbers from all annual reports received from the Provincial Standards Committees and Area Standards Committees by region for the months of January 2024– February 2025.

For Information BN - Committee Reports

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Interlake-Eastern	Clinical Audits: Adverse Patient Occurences	32	31	1			
	Referred Concern	0					
	Random Audit	51	50	1			
	Not an APO	0					
	Practice Audit or Interactive Audit	0	Committees Include: Interlake-Eastern Area Standards Committee, Selkirk Area Standards Committee, Selkirk Mental Health Centre Standards Committee				
	Newsletter Item	0					
	Referral to Another Organization	0					
	Number of Meetings in 2024	4					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Northern	Clinical Audits: Adverse Patient Occurences	11	5	5	1		
	Referred Concern	0					
	Random Audit						
	Not an APO	0					
	Practice Audit or Interactive Audit	0	Committees Include: Northern Area Standards Committee				
	Newsletter Item	0					
	Referral to Another Organization	0					
	Number of Meetings in 2024	4					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Prairie-Mountain	Clinical Audits: Adverse Patient Occurences	253	251	2			
	Referred Concern	0					0
	Random Audit	0					
	Not an APO						
	Practice Audit or Interactive Audit	0	Committees Include: Prairie-Mountain Area Standards Committee, Brandon Regional Health Centre Area Standards Committee, Brandon Regional Health Centre Psychiatry Standards				
	Newsletter Item	0					
	Referral to Another Organization						
	Number of Meetings in 2024	3					

For Information BN - Committee Reports

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Southern	Clinical Audits: Adverse Patient Occurences	199	162	37			
	Referred Concern	22	12	8	2		
	Random Audit	26	15	7	4		
	Not an APO	2					
	Practice Audit or Interactive Audit	8	Committees Include: Southern Area Standards Committee, Portage Area Standards Committee, Boundary Trails Health Centre Standards Committee, C.W. Wiebe Medical Centre Standards Committee, Eden Mental Health Centre Standards Committee				
	Newsletter Item	2					
	Referral to Another Organization	6					
	Number of Meetings in 2024	4					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
Provincial Committees	Clinical Audits: Adverse Patient Occurences	124	121	1			1
	Referred Concern	9	4	2			1
	Random Audit	26	25				
	Not an APO	13					
	Practice Audit or Interactive Audit	5	Committees Include: CancerCare Standards Committee, Endoscopy Provincial Standards Committee, Orthopedic Surgery Provincial Standards Committee				
	Newsletter Item	4					
	Referral to Another Organization	8					
	Number of Meetings in 2024	4					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
WRHA	Clinical Audits: Adverse Patient Occurences	0	0	0			
	Referred Concern						
	Random Audit						
	Not an APO	0	0	0			
	Practice Audit or Interactive Audit		Committees Include: Winnipeg Regional Health Authority Standards Committee				
	Newsletter Item						
	Referral to Another Organization						
	Number of Meetings in 2024	0					

			Suggested Change Outcomes		Required Change Outcomes		
	Cases Reviewed	Total	Option #1 Reasonable Care	Option #2 Self-Reflective Quality Improvement Plan	Option #3 Negotiated Improvement Plan	Option #4 Prescribed Learning Plan	Option #5 Referral to the Registrar
All Regional Area Standards Committees	Clinical Audits: Adverse Patient Occurences	619	570	46	1	0	1
	Referred Concern	31	16	10	2	0	1
	Random Audit	103		8	4	0	0
	Not an APO	15	0	0	0	0	0
	Practice Audit or Interactive Audit	13					
	Newsletter Item						
	Referral to Another Organization	14					
	Number of Meetings in 2024	19					

Respectfully submitted by
Dr. Roger Süss
Chair, Central Standards Committee