Land Acknowledgment

We acknowledge we are gathered on Treaty 1 Territory and that CPSM regulates the practice of medicine on the Treaty Territories of Treaty 1, Treaty 2, Treaty 3, Treaty 4, Treaty 5, and Treaty 5-Adhesion. We recognize these are the ancestral lands of the Anishinaabeg (Anish-in-NAW-bay), Anishininewuk (ANISH-in-nin-new-uk), Cree, Dakota Oyate Dah-KO-tah oh-yah-Day, Denesuline (Deh-nay-soo-li-nay), and Nehethowuk (Neetho-uk) Nations, and the National Homeland of the Red River Métis.

We acknowledge that Northern Manitoba includes lands that were and are the ancestral lands of the Inuit.

CPSM acknowledges and apologizes for its role in contributing to the disproportionate health inequities that exist amongst the Indigenous communities in Manitoba. These failures include inadequately addressing Indigenous-specific racism by medical practitioners. We respect and celebrate the resilience and strength First Nations, Inuit and Métis people have displayed in the face of genocide and the displacement of their land and water.

It is a privilege to regulate the practice of medicine on these lands and CPSM pledges to improve. The first step to improving is continual acknowledgment of our respect for the spirit and intent of Treaties, and our commitment to working in partnership with First Nations, Inuit and Métis people in the spirit of truth, reconciliation and collaboration.

Last updated on May 22, 2026

CPSM Pipe Ceremony on Treaty 1, June 6, 2025.

September 23, 2026 CPSM Council

Wednesday, September 23, 2026 | 8:30 a.m. – 3:30 p.m.|

AGENDA

CPSM Office – Brown Room
1000 – 1661 Portage Avenue

Time		Item		Action	
5 min	8:30 am	1.	Opening Remarks and Land Acknowledgment		Dr. Penner
0 min	8:35 am	2.	Agenda – Approval		Dr. Penner
0 min	8:35 am	3.	Call for Conflict of Interest		Dr. Penner
5 min	8:35 am	4.	Consent Agenda i. Council Meeting Minutes • June 24, 2026 ii. Special Meeting Minutes • July 14, 2026 iii. Special Meeting Minutes • August 12, 2026 iv. Elections Committee Appointment v. First Nation, Inuit and Metis Advisory Circle • Terms of Reference • Membership Appointments vi. Council Policy Amendments • Registration of Clinical and Physician Assistants and Physician Assistant Students • Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice) and Provisional (Non-Practicing) Class • Registration in Provisional Specialty Practice - Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes	For Approval	Dr. Penner
30 min	8:40 am	5.	IMG Working Group Final Report	For Approval	Dr. Shenouda/ Mr. de Jong/ Dr. Man
5 min	9:10 am	6.	Accredited Facilities Bylaw Revisions - Consultation	For Approval	Mr. Triggs/ Ms. Penny
5 min	9:15 am	7.	The Affairs of the College Bylaw Revisions – Consultation	For Approval	Dr. Penner

Time		Item		Action	
10 min	9:20 am	8.	Prescribing Opioids and Prescribing Benzodiazepines and Z-Drugs Working Group Update	For Discussion	Dr. Penner
10 min	9:30 am	9.	Registrar and CEO Report • Performance Metrics Update • Operational Reports • Minister Public Roster Appointments • Minister Appointed Council Public Representative Vacancy	For Information	Dr. Mihalchuk
15 min	9:40 am	10.	Populations Identifying Gaps in Care	For Discussion	Dr. Penner/ Dr. Mihalchuk
30 min	9:55 am	11.	Restorative Practice Program Presentation	For Information	RPP Team
5 min	10:25 am	12.	CPSM All-Staff Orange Shirt Day	For Information	Dr. Mihalchuk/ Dr. Bruin
20 min	10:30 am		------ BREAK ------		
15 min	10:50 am	13.	Approved Jurisdiction Draft Policy	For Approval	Mr. de Jong
45 min	11:05 am	14.	AI Report and Advice to the Profession Updates	For Discussion	Dr. Mihalchuk/ Mr. de Jong
10 min	11:50 am	15.	Advice to the Profession – Point of Care Ultrasound (POCUS)	For Discussion	Dr. Mihalchuk
5 min	12:00 pm	16.	Council Committees Reports (questions taken) • Executive Committee • Board of Assessors • Complaints Committee • Central Standards Committee • Elections Committee • Finance, Audit & Risk Management Committee • Inquiry Committee • Investigations Committee • Program Review Committee	For Information	Dr. Penner
40 min	12:05 pm		------ LUNCH ------		
120 min	12:45 pm	17.	Council Training: Governance In Action Presenter: Ms. Judy Murphy	For Information	Ms. Dupuis/ Ms. Murphy
30 min	2:45 pm	18.	In Camera	For Discussion	
	3:15 pm	19.	Review of Self-Evaluation of Governance Process- survey via email		Dr. Penner
6 hours, 45 minutes			Estimated time of sessions		

Regulated Health Professions Act

Duty to serve the public interest

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

CPSM Mandate

10(2) A college has the following mandate:

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

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

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

COUNCIL MEETING
SEPTEMBER 23, 2026
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Consent Agenda

BACKGROUND:

To make Council meetings more efficient and effective the consent agenda is 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 are on this consent agenda for approval. See attached for details on each item.

- **i.** Council Meeting Minutes – June 24, 2026
- **ii.** Special Council Meeting Minutes – July 14, 2026
- **iii.** Special Council Meeting Minutes – August 12, 2026
- **iv.** Elections Committee Appointment
- **v.** First Nation, Inuit and Métis Advisory Circle
  - Terms of Reference
  - Membership Appointments
- **vi.** Council Policy Amendments

- Registration of Clinical Assistants and Physician Assistants and Physician Assistant Students
- Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes
- Registration in Provisional Specialty Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

All items on the consent agenda are approved as presented.

Notice of Motion for Approval Briefing Note Prepared by: Mr. Mike Triggs, General Counsel

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Winnipeg, MB R3J 3T7
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MINUTES OF COUNCIL

Council of The College of Physicians and Surgeons of Manitoba met on June 24, 2026, at the CPSM Office with an option to join virtually via Zoom.

CALL TO ORDER

The meeting was called to order at 08:30 a.m. by the Chair of the meeting, Dr. Charles Penner.

COUNCILLORS:
Ms. Lesile Agger, Public Councillor **(V)**
Dr. Rafiq Andani, Winnipeg
Dr. Kevin Convery, Morden
Mr. Allan Finebilt, Public Councillor
Ms. Lynette Magnus, Public Councillor
Dr. Rizwan Manji, Winnipeg **(V)**
Dr. Jennifer McNaught, Winnipeg
Dr. Lisa Monkman, Scanterbury
Dr. Peter Nickerson, Winnipeg **(V)**
Dr. Charles Penner, Brandon
Ms. Leanne Penny, Public Councillor
Dr. Nicole Vosters, Selkirk
Dr. Alewyn Vorster, Treherne
Dr. Nader Shenouda, Oakbank
Dr. Yasam Yazdizadeh, Regulated Associate

STAFF:
Dr. Ainslie Mihalchuk, Registrar & CEO
Dr. Guillaume Poliquin, Assistant Registrar, C/I
Mr. Mike Triggs, General Counsel
Mr. Paul Penner, Chief Financial Officer
Dr. Sonja Bruin, Assistant Registrar, Quality **(V)**
Mr. Jeremy de Jong, Director Registration & Innovation
Ms. Sherry Dupuis, Executive Director People & Culture
Ms. Wendy Elias-Gagnon, Communications Director
Ms. Barbie Rodrigues, Senior Executive Assistant
Ms. Helena Tessier, Executive Assistant
Ms. Stacey Carlson, Executive Assistant
Dr. Marilyn Singer, Medical Consultant, QI **(V)**
Dr. Liesel Möller, Medical Consultant, QI **(V)**
Ms. Mira Bokhaut, Legal Consultant, Corporate **(V)**

REGRETS:
Mr. Neil Cohen, Public Councillor

1. OPENING REMARKS AND LAND ACKNOWLEDGEMENT

Dr. Penner conveyed the CPSM Land Acknowledgment and:

- Spoke in remembrance of Ms. Marvelle McPherson, CPSM Council public representative from 2017 to 2026. Council held a moment of silence.
- Acknowledged incoming Councillors: Dr. R. Andani, Dr. N. Vosters, Dr. Y. Yazdizadeh as well as Dr. Monkman's re-election.
- Reminded Councillors to complete required annual forms.
- Acknowledged Ms. Lynette Magnus for her role as Complaints Committee Chair in sunsetting the committee.

2. ADOPTION OF AGENDA

MOVED BY MR. ALLAN FINEBILT, SECONDED BY DR. NADER SHENOUDA AND ADPOTED BY CONSENSUS:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Penner called for any conflicts of interest to be declared and any requests for in-camera session. There being none, the meeting proceeded.

4. CONSENT AGENDA

Dr. Penner provided an overview of how the Consent Agenda is used. Dr. Penner asked if any Councillors wished to discuss any of the consent agenda items.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. NADER SHENOUDA:
CARRIED

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

i. Council Meeting Minutes – March 18, 2026
ii. New Policies:
    i. Council Policy – Appeals from Registration Decisions made by the Registrar/Board of Assessors
    ii. Council Policy – Appeals from Decisions made by the Program Review Committee
    iii. Repeal of Practice Direction – Appeals Pursuant to S 38 and 183(7) of the RHPA

5. REGULATION STATUS UPDATE

Reducing Barriers for Provisional Registration of Family Registrants

Proposed amendments to section 3.19(1)(b) of the CPSM General Regulation (Manitoba Regulation 163/2018) sent for consultation in April 2025 resulted in changes necessitating further consultation in November 2025. Government advised that since the November 2025 consultation did not include a French version along with the English version a third consultation was required.

A motion was made by Dr. Penner to move forward with a third consultation.

MOVED BY DR. DR. ALEWYN VORSTER, SECONDED BY DR. RAFIQ ANDANI:
CARRIED

Council approve the proposed amendments to the CPSM General Regulation (Manitoba Regulation 163/2018) for release for public consultation.

Clinical Assistants' Use of the Title - Doctor

On May 26, 2025, after 30-day consultation, Council approved amending the *CPSM General Regulation* to allow Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "CLA" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.

Council decided the regulation change was to come into effect on June 1, 2026, to provide CPSM sufficient time to educate registrants and the public regarding the amendment.

On June 26, 2025, CPSM was advised by the Department of Health that Legislative Counsel informed that CPSM would have to do another 30-days of consultation because it decided to make the effective date 2026 (the consultation did not specify an effective date). CPSM has requested numerous times in emails and in person meetings with senior officials in the Department of Health that this be addressed with Legislative Counsel so that the regulation amendments can go to Cabinet for approval.

6. CONSULTATION FOR REGULATORY CHANGES TO ADDRESS EMERGENCY ROOM SHORTAGES

Consultation on proposed amendments to *CPSM General Regulation* (Manitoba Regulation 163/201*)* to create a new pathway for the registration of Internationally Trained Physicians (ITPs) with extensive clinical training and experience in Emergency Medicine was conducted from May 6 to June 5, 2026. 14 consultation responses were received from registrants and 4 responses from stakeholders. Council considered the responses.

MOVED BY DR. DR. CONVERY, SECONDED BY MS. LEANNE PENNY:
CARRIED

Council requests Cabinet approve the proposed amendments to *CPSM General Regulation* (Manitoba Regulation 163/201) as presented.

7. PRACTICE READY ASSESSMENT (PRA) FOR EMERGENCY MEDICINE (EM) PHYSCIANS

The PRA EM-MB establishes a mechanism to assess whether qualified Internationally Trained Physicians (ITPs) can safely and independently practice within the Emergency Department practice in Manitoba following a structured supervised practice period.

MOVED BY DR. DR. CONVERY, SECONDED BY MR. ALLAN FINEBLIT:
CARRIED (15 for, 1 abstaining)

The proposed governance model and structure of the Manitoba Practice Ready Assessment for Emergency Medicine (PRA EM-MB) is approved as presented for implementation of the date Cabinet approves the proposed regulation creating a provisional (other approved training) class.

8. REGISTRATION POLICIES NEEDING TO BE ADDED/UPDATED FOR THE PROPOSED PROVISIONAL (OTHER APPROVED TRAINING) CLASS OF REGISTERATION

If the proposed amendments to the CPSM General Regulation (Agenda 6) are approved by Cabinet consequential amendments will be required to numerous existing Registration policies as well as creating a new Council Policy, that being the following:

1) **NEW** Council Policy – *Registration in the Provisional (Other Approved Training), Assessment Candidate (Other Approved Training), and Provisional Non-Practicing*.
2) **AMENDMENTS** to the Council Policy – *Fields of Practice and Specialist Register*.
3) **AMENDMENTS** to the Council Policy – *Certificates or Practice***.**
4) **AMENDMENTS** to the Council Policy – Supervision of Provisional Registrants.
5) **AMENDMENTS** to the Council Policy – *The Manitoba Practice Assessment Program ("MPAP").*
6) **AMENDMENTS** to the Council Policy – *Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes*.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. NICOLE VOSTERS:
CARRIED

That Council approve the new Council Policy set out in Appendix A and the amendments to the Council Policies set out in Appendices B through F, as presented to take effect on the date Cabinet approves the proposed Regulation creating a Provisional (other approved training) class.

--------BREAK---------- (10:15 AM to 10:35 AM)

9. ACCREDITED FACILITIES BYLAW AMENDMENT

The Program Review Committee (PRC) recommended CPSM consults with registrants, stakeholders, the public and Minister on proposed amendments to the *Accredited Facilities Bylaw*.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. NADER SHENOUDA:
CARRIED

The proposed amendments to the *Accredited Facilities Bylaw* be posted for 30 days for consultation with registrants and interested stakeholders, and that the proposed amendments be provided to the Minister for their review and comment.

10. FEE BYLAW AMENDMENTS FOR 2026-27

The *Fee Bylaw* contains the rules, policies and a comprehensive schedule of fees charged by CPSM. The fees are grouped under the categories of registration, certificates of practice, medical corporations, non-hospital medical surgical facilities fees and various sundry fees charged by CPSM.

The *Fee Bylaw* contains the provision that the annual registration fee is to increase automatically every year by the rate of Manitoba Consumer Price Index. Other increases must be approved by Council.

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

The *Fee Bylaw* amendments are approved as presented.

11. CPSM COUNCIL ELECTION PROCESS

Dr. Convery reviewed the 2026 CPSM Council election process which was assessed as a significant improvement to the previous process. Key topics identified by the Elections Committee for going forward are:

1) The committee needs to commence its recruitment work well in advance of the call for nominations going out.
2) The committee needs to clearly define its role for screening candidates.
3) The committee needs to develop strategies to increase voter participation.
4) The voting process needs clear and concise prompts to ensure voters know they have multiple votes when more than one seat is available for a district.
5) Templates for application submissions should be consistent, relevant and quality information is received.

The Election Committee is set to meet in November 2026 in preparation for the March 2027 election.

12. GOVERNANCE POLICY AND THE AFFAIRS OF THE COLLEGE BYLAW AMENDMENTS

The *Affairs of the College Bylaw* and the *Governance Policy* are the two primary CPSM documents that address the expectations and responsibilities for Councillors' behaviour. The Executive Committee has reviewed these documents and identify improvements. Council may only approve amendments to the *Bylaw* after receiving consultation feedback, but they can amend the *Policy* without consultation.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. LISA MONKMAN:
CARRIED

That Council approved the proposed amendments to the *Affairs of the College Bylaw* be circulated to registrants and stakeholders for consultation.

MOVED BY DR. DR. CONVERY, SECONDED BY MS. LEANNE PENNY:
CARRIED

That Council approve the *Governance Policy* Option 1 amendments as presented effective June 24, 2026.

13. CPSM 2026/2027 COMMITTEES

Pursuant to section 2.3.1 of the *Governance Policy*, the Executive Committee presented recommendations of membership on its various committees for 2026/2027.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. NADER SHENOUDA:
CARRIED

Council approves that the 2026/2027 membership of Committees as outlined in the presented briefing note and the accompanying committee membership charts.

14. FINANCIAL MANGEMENT POLICY AMENDMENTS

MOVED BY DR. DR. CONVERY, SECONDED BY DR. RAFIQ ANDANI:
CARRIED

Council approves amendments to the Financial Management Policy as presented.

15. PRESCRIBING OPIOIDS AND PRESCRIBING BENZODIAZEPINES AND Z-DRUGS WORKING GROUP UPDATE

Dr. Penner advised the goal of the working group is to combine the existing two standards into one significantly shorter document. It is anticipated that a draft standard of practice with contextual information will be brought forward at the December 2026 Council meeting.

16. CONSULTATION FOR NEW STANDARD OF PRACTICE – ENTERING A NEW PRACTICE SETTING

At its March 18, 2026 meeting, Council authorized CPSM to seek input for 30 days from registrants, external partners, and the public on a draft Standard of Practice – Entering a New Practice Setting. The consultation period was from April 17, 2026 to May 21, 2026. Nine consultation responses were received.

Revisions to the exiting draft Standard of Practice have been made based on feedback from the consultation.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. RAFIQ ANDANI:
CARRIED

Council enact the new Standard of Practice – Entering a New Practice Setting, in the form presented, with an effective date of October 1, 2026.

--------LUNCH---------- (12:00 PM to 12:45 PM)

17. QUALITY IMPROVEMENT PROGAM CYCLE 2 2026-2032 - PROPOSED CHANGES

The CPSM Quality Improvement (QI) Program began operations in January 2019 requiring all physicians to participate in a 7-year cycle. In this 7-year cycle there were 3 categories of activity. All included a self-reflective practice review and development of a quality plan. Category 2 added either a chart review done at CPSM or multisource feedback. Category 3 participants did both multisource feedback and an interactive chart review. Participants were placed in Categories based on random selection and by use of physician risk/protective factors. Participants with higher risk scores were stratified into higher levels of participation (Category 2 or 3).

For the next 7-year cycle the QI Program has proposed to eliminate Category 3. Category 2 will include an option for an interactive audit for participants felt to be at highest risk. Category 1 (self-reflective practice review and quality plan) will expanded to include one additional activity selected from a list presented to participants.

18. RISK MANAGEMENT EDUCATION SESSION BY HIROC

Ms. Lori Bortovoy and Nataly Farshait from Healthcare Insurance Reciprocal of Canada (HIROC) virtually facilitated an educational session.

19. REGISTRAR & CEO REPORT

Dr. Mihalchuk reported on:

- recent internal people and culture, external relations and provincial engagements
- 2025-2026 4th quarter performance metrics reporting scorecard
- Operational Reports from each CPSM department
- the Community Living Manitoba request – Healthcare for Persons with Intellectual Disabilities and/or Persons with Autism
- the review cycle for CPSM documents

20. COMMITTEE REPORTS

The following Reports were presented to Council for information:

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

--------BREAK---------- (2:15 PM to 2:35 PM)

21. PERFORMANCE METRICS – COMPLAINTS AND INVESTIGATIONS

Dr. Poliquin presented proposed Complaints & Investigation performance metrics for:

- time-to-triage,
- response to serious complaints,
- investigation complexity measure and
- monitoring visits

The metrics are designed to provide Council with meaningful information to assess the operations of the Complaints & Investigations resulting from the fundamental process changes that began in July 2025.

22. PROPOSED AMENDMENTS TO CPSM GENERAL REGULATION (MANTIOBA REGULATION 163/2018) – APPROVED JURISDICTION PATHWAY

A draft regulation establishing an approved jurisdiction pathway to full licensure within the *Regulated Health Professions Act* (RHPA) framework was presented to Council.

MOVED BY DR. DR. CONVERY, SECONDED BY DR. RAFIQ ANDANI:
CARRIED

Council approve the proposed amendments to the CPSM General Regulation (Manitoba Regulation 163/2018) for release for public consultation, subject to finalization of the consultation document.

23. COUNCIL ATTENDANCE

Council reviewed the 2025-2026 Council attendance report.

24. IN CAMERA SESSION

An in-camera session was held commencing at 3:14 pm.

There being no further business, the meeting ended at 3:41 pm.

Information of note for Councillors follows:

25. REVIEW OF SELF-EVALUATION OF GOVERNANCE PROCESS – SELF SURVEY VIA EMAIL COUNCIL TRAINING

The self-survey sent to Councillors is to be returned no later than 4:00 pm on Friday, June 26, 2026.

26. CPSM 2026-2027 COUNCIL COMMITTEE DATES

A listing of the 2026/27 meeting dates were presented to Council for information. The relevant CPSM administrative staff would be sending formal meeting invites after the June 24, 2026 Council

to relevant committee membership.

27. COLLABORATIVE CARE STANDARD OF PRACTICES AND CONTEXTUAL INFORMATION DOCUMENTS

The updated Standards of Practice on Collaborative Care became effective June 1, 2026. Notifications were sent to registrants and public representatives as well as being published on the CPSM website and home page.

The standard is the culmination of over two years of development and is substantially different than the previous iteration.

There are now three separate Standards, each standard is supported with its own contextual document which includes FAQs to assist with applying the standard in practice.

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Dr. C. Penner, President

_____

Dr. A. Mihalchuk, Registrar & CEO

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MINUTES OF COUNCIL

A special meeting of the Council of The College of Physicians and Surgeons of Manitoba was called for an electronic vote via a July 14, 2026 email.

The Notice of Special Meeting and Notice of Motion was sent on behalf of Dr. Charles Penner for the following:

> Pursuant to *section 2.2.3*. of the *Governance Policy*, Dr. Charles Penner is calling an electronic vote on the following motions:
>
> THAT Council approves:
> **1.** Ms. Lynette Magnus be re-appointed to Council for a four-year term commencing July 17, 2026.
> **2.** Ms. Lynette Magnus is appointed to the CPSM Executive Committee commencing July 17, 2026.
> **3.** Ms. Lynette Magnus is removed from the CPSM Election Committee effective July 17, 2026.
>
> ACTION REQUIRED: please reply to ALL when completing your vote which is required *by noon Friday, July 17*.
>
> **BACKGROUND:**
>
> Lynette Magnus is a public representative on Council appointed by Council. Her second four-year term expired in June 2026. At the June 24, 2026 Council meeting Ms. Magnus was appointed to the Executive Committee. However, there was an oversight in the preparation of the materials to re-appoint her to Council. As such, she is not entitled to be a member of the Executive Committee. To rectify this oversight Council is asked to re-appoint Ms. Magnus to Council and to appoint her to the Executive Committee effective July 17, 2026. Ms. Magnus has agreed to these appointments should Council re-appoint her.
>
> It was also identified that Ms. Magnus is serving a 2-year term on the Election Committee. The Governance Policy specifically prohibits any members of the Executive Committee other than the President-Elect from being a member of the Election Committee, as such if Ms. Magnus is appointed to the Executive Committee she will have to removed from the Election Committee. At its September meeting Council can discuss a suitable replacement for the Election Committee.
>
> By way of background, Ms. Magnus is a Chartered Accountant. She sits on the Finance Audit and Risk Management Committee, and recently, as its Chair, wound down the Complaints Committee. She has participated in many CPSM Working Groups to develop Standards of

Practice. Ms. Magnus is the former Chair of the Board of Governors of the University of Manitoba.

The Motion was approved. As of the closing deadline of Friday, July 17, 2026 at 12:00 PM, there were 11 votes in favour and none in opposition.

_____

Dr. C. Penner, President

_____

Dr. A. Mihalchuk, Registrar & CEO

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MINUTES OF COUNCIL

A special meeting of the Council of The College of Physicians and Surgeons of Manitoba was held virtually via ZOOM on August 12, 2026.

CALL TO ORDER

The meeting was called to order at 5:00 p.m. by the Chair of the meeting, Dr. Charles Penner.

COUNCILLORS:
Dr. Rafiq Andani, Winnipeg
Mr. Neil Cohen, Public Councillor
Dr. Kevin Convery, Morden
Mr. Allan Finebilt, Public Councillor
Ms. Lynette Magnus, Public Councillor
Dr. Rizwan Manji, Winnipeg
Dr. Lisa Monkman, Scanterbury
Dr. Peter Nickerson, Winnipeg
Dr. Charles Penner, Brandon
Ms. Leanne Penny, Public Councillor
Dr. Alewyn Vorster, Treherne
Dr. Nader Shenouda, Oakbank
Dr. Yasam Yazdizadeh, Regulated Associate

STAFF:
Dr. Ainslie Mihalchuk, Registrar & CEO
Mr. Mike Triggs, General Counsel
Mr. Jeremy de Jong, Director of Registration & Innovation
Ms. Barbie Rodrigues, Senior Executive Assistant

REGRETS:
Dr. Nader Shenouda

ABSENT:
Ms. Lesile Agger, Public Councillor
Dr. Jennifer McNaught, Winnipeg
Dr. Nicole Vorster, Selkirk

1. OPENING REMARKS

Dr. Penner opened the meeting at 5:00 pm

2. LAND ACKNOWLEDGEMNT

Dr. Penner conveyed the CPSM Land Acknowledgment.

3. ADOPTION OF AGENDA

IT WAS MOVED BY DR. KEVIN CONVERY AND SECONDED BY MR. NEIL COHEN AND ADOPTED BY CONSENSUS:

CARRIED:

That the agenda be approved as presented.

4. CALL FOR CONFLICT OF INTEREST

Dr. Penner 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.

5. PROPOSED AMENDMENTS TO CPSM GENERAL REGULATION (MR 163/2018) – REDUCING BARRIERS FOR PROVISIONAL REGISTRATION OF FAMILY REGISTRANTS

On June 24, 2026, Council approved a third consultation be undertaken on amendments to section 3.19 of the CPSM General Regulation (163/2018). A copy of the Consultation Draft was attached as Appendix A to the Briefing Note for this Agenda Item. The consultation occurred between July 9 to August 10, 2026, and 8 responses were received, 5 from registrants and 2 from stakeholders and 1 from a member of the public.

After reviewing the consultation results:

IT WAS MOVED BY DR. CONVERY, SECONDED BY MS. LEANNE PENNY:

CARRIED:

That Council approve the proposed amendments to subclause 3.19 of the CPSM General Regulation (163/2018) as contained in *Appendix A*.

6. PROPOSED AMENDMENTS TO CPSM GENERAL REGULATION (MR 163/2018) – APPROVED JURISDICTION PATHWAY

On June 24, 2026, Council approved consultation be undertaken on proposed amendments to sections 3.8 and 3.44 of *CPSM General Regulation* that establish an approved jurisdiction pathway to full licensure. A copy of the Consultation Draft was attached as Appendix A to the Briefing Note for this Agenda Item.

16 responses were received, 2 from members of the public, 5 from stakeholders, and 9 from registrants.

After reviewing the consultation results:

IT WAS MOVED BY DR. CONVERY, SECONDED BY MR. ALLAN FINEBLIT:

CARRIED:

Whereas the Government of Manitoba has provided its commitment to work with CPSM to develop further regulatory amendments to provide greater flexibility in the approval of jurisdictions. The review will explore whether training, accreditation, certification, and regulatory oversight frameworks can be recognized as alternative indicators of comparability, without necessarily requiring formal postgraduate training equivalency. This algins with our work with national partners through FMRAC.

Council approves the proposed amendments to sections 3.8 and 3.44 of the *CPSM General Regulation (163/2018)* as contained in *Appendix A*.

There being no further business, the meeting ended at 5:28 p.m.

_____

Dr. C. Penner, President

_____

Dr. A. Mihalchuk, Registrar & CEO

COUNCIL MEETING
SEPTEMBER 23, 2026
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Elections Committee Appointment

BACKGROUND:

The current members of the Elections Committee are:

- Dr. Kevin Convery, President Elect
- Dr. Rizwan Manji
- Mr. Neil Cohen

The Committee's terms of reference in the Governance Policy state the following about Committee composition:

> **4.18.3** Composition
>
> **4.18.3.a** The Elections Committee shall consist of:
>
> **4.18.3.a.i** The Chair, who must be the President Elect.
>
> **4.18.3.a.ii** At least one Councillor who is a public representative.
>
> **4.18.3.a.iii** At least one Councillor who is a regulated registrant.
>
> **4.18.3.b** Other than the President Elect no member of the Executive Committee may be on the Elections Committee.
>
> **4.18.3.c** Members of the Elections Committee cannot serve for more than 2 annual elections.

Ms. Lynette Magnus was the fourth member of the Committee. However, because she was recently appointed to the Executive Committee and **section 4.18.3.b** of the Governance Policy prohibits members of the Executive Committee, other than the President Elect, from being on the Committee she is no longer on the Elections Committee.

Pursuant to **section 2.3.1** of the Governance Policy, the Executive Committee is responsible for recommending to Council candidates for appointment to Committees.

The Executive Committee met on September 2, 2026, and recommended Ms. Leanne Penny be appointed to the Elections Committee.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approve the appointment of Leanne Penny to the Elections Committee effective September 23, 2026, for a term ending June 22, 2028.

Notice of Motion for Approval Briefing Note Prepared by: Mr. Mike Triggs, General Counsel

COUNCIL MEETING
SEPTEMBER 23, 2026
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **First Nations, Inuit, and Métis Advisory Circle – TOR and Membership**

BACKGROUND:

In 2021, CPSM acknowledged that meaningful progress toward reconciliation with Indigenous peoples in Manitoba required collaboration and guidance from Indigenous voices. An Advisory Circle was invited to share knowledge and perspectives, and the following was its purpose as defined in its original Terms of Reference:

> "*The purpose of the Truth and Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners Advisory Circle is to provide advice and recommendations to help CPSM reflect on its own processes and identify how it can and better guide the physicians and other CPSM members who provide medical care to Indigenous patients and to create better understanding and support of Indigenous patients*."

The Advisory Circle developed seven recommendations, which CPSM accepted on September 29, 2022.

1. CPSM to issue an Apology and Statement by CPSM on Indigenous-Specific Racism (prepared by CPSM, reviewed by TRC Circle).
2. CPSM Land Acknowledgment (prepared by CPSM, reviewed by TRC Advisory Circle)
3. Standard of Practice – Practicing Medicine to Prevent Indigenous-Specific Racism.
4. Restorative Justice Approach to Complaints and Investigations (includes – Creating a Culture of Receiving and Addressing Complaints by Indigenous Patients).
5. Mandatory Indigenous-Specific Anti-Racism Training for CPSM Registrants and Staff.
6. Mentorship/Leadership at CPSM (Includes Creating an Open Culture to Support Indigenous Physicians).
7. Definition of Indigenous-Specific Racism (adopt In Plain Sight and FMRAC) and Gather Examples of Racism by Medical Professionals (to be used for educational purposes).

Over the next two and half years CPSM in consultation with the Advisory Circle made progress towards implementing the seven recommendations. The most significant steps being the creation of the *Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism* and the Restorative Practices Program.

While this represents meaningful progress, it does not mark the end of CPSM's reconciliation responsibilities. Indigenous patients continue to experience racism and inequity within the healthcare system, and systemic change remains necessary.

The Advisory Circle met with CPSM leadership on January 28, April 22, and July 22, 2026, to consider updating the Advisory Circle's Terms of Reference to provide continued meaningful contributions to CPSM's mandate going forward. Attached as ***Appendix A*** is the proposed updated Terms of Reference.

Changes to the original terms of reference include:

- changing its name to *First Nations, Inuit, and Métis Advisory Circle*
- incorporating the Advisory Circle's history into the document's background
- operationalizing the Advisory Circle's purpose
- establishing the Advisory Circle's leadership and membership

Current Membership, alphabetical order is:

Leslie Agger - Councillor
Dr. Mandy Buss
Wayne Inuglak Clark
Dr. Lance Crook
Dr. Linda Diffey
Debra Beach Ducharme
Dr. Sara Goulet
Dr. Joel Kettner
Lorraine McLeod
Dr. Sheila Menard
Dr. Lisa Monkman – Councillor/Chair
Leslie Spillett
Dr. Nicole Vosters - Councillor

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

> The Terms of Reference for the First Nations, Inuit, and Métis Advisory Circle, attached as Appendix A, is approved as presented.
>
> The Registrar request the First Nations, Inuit, and Métis Advisory Circle provide recommendations on membership and staggered terms for appointment to the Circle.

Notice of Motion for Approval Briefing Note Prepared by: Mr. Mike Triggs, General Counsel

First Nations, Inuit, and Métis Advisory Circle

TERMS OF REFERENCE

The College of Physicians and Surgeons of Manitoba

UPDATED: July 22, 2026

Terms of Reference
2026

Background:

In 2021, CPSM acknowledged that meaningful progress toward reconciliation with the First Nations (status and non-status), Inuit, and Métis in Manitoba required collaboration and guidance from their voices. An Advisory Circle was invited to share knowledge and perspectives, and the following was its purpose as defined in its original Terms of Reference:

> "*The purpose of the Truth and Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners Advisory Circle is to provide advice and recommendations to help CPSM reflect on its own processes and identify how it can and better guide the physicians and other CPSM members who provide medical care to Indigenous patients and to create better understanding and support of Indigenous patients*."

The Advisory Circle developed seven recommendations, which CPSM accepted on September 29, 2022.

1. CPSM to issue an Apology and Statement by CPSM on Indigenous-Specific Racism (prepared by CPSM, reviewed by TRC Circle).
2. CPSM Land Acknowledgment (prepared by CPSM, reviewed by TRC Advisory Circle)
3. Standard of Practice – Practicing Medicine to Prevent Indigenous-Specific Racism.
4. Restorative Justice Approach to Complaints and Investigations (includes – Creating a Culture of Receiving and Addressing Complaints by Indigenous Patients).
5. Mandatory Indigenous-Specific Anti-Racism Training for CPSM Registrants and Staff.
6. Mentorship/Leadership at CPSM (Includes Creating an Open Culture to Support Indigenous Physicians).
7. Definition of Indigenous-Specific Racism (adopt In Plain Sight and FMRAC) and Gather Examples of Racism by Medical Professionals (to be used for educational purposes).

Over the next two and a half years, CPSM, in consultation with the Advisory Circle, made progress towards implementing the seven recommendations. The most significant steps were the creation of the *Standard of Practice – Practicing Medicine to Eliminate Anti-Indigenous Racism* and the Restorative Practices Program.

While this represents meaningful progress, it does not mark the end of CPSM's reconciliation responsibilities. First Nations, Inuit, and Métis patients continue to experience racism and inequity within the healthcare system, and systemic change remains necessary.

Operationalizing the Advisory Circle's Purpose:

CPSM must establish an ongoing, meaningful role for the Advisory Circle, ensuring their guidance continues to influence regulatory actions. The Advisory Circle's advice should be respected and acted upon—not merely sought as a formality.

CPSM retains final decision-making responsibility over standards and policies, balancing statutory obligations with Advisory Circle input.

CPSM recognizes that First Nations, Inuit, and Métis perspectives must be integrated early in policy development; late involvement risks tokenism and erodes trust.

- Advisory Circle will be formally involved in developing/reviewing standards and policies impacting their peoples' health, cultural safety, or equity.
- Guidance will inform CPSM's work from the outset, not as an afterthought.
- At the start of a review, CPSM and the Advisory Circle Keeper assess the relevance of First Nations, Inuit, and Métis perspectives on the standards/policies to be reviewed.
- Draft materials are shared before positions are finalized; feedback is documented and incorporated.
- CPSM reports back to the Advisory Circle on outcomes and reasons for non-adoption of recommendations.
- This approach embeds First Nations, Inuit, and Métis perspectives while CPSM retains accountability for final decisions.

CPSM's Restorative Practices Program is an important means for CPSM to address anti-Indigenous racism by focusing on harm and relationship repair. To maintain the Advisory Circle's engagement with the Program, CPSM will provide updates on the Program twice yearly.

Leadership and Membership:

The Advisory Circle Keeper (who facilitates the functioning of the Advisory Circle) is appointed by CPSM Council for a 1-to-2-year term, which may be renewed. Members of the Advisory Circle will be appointed by CPSM Council based on discussions with the Advisory Circle Keeper for a term of 1 to 3 years, which may be renewed.

The Advisory Circle Membership is to be led by and include physicians, CPSM-regulated associate registrants, and community members (i.e. scholars, leaders, elders, traditional knowledge keepers, and traditional healers) who are First Nations, Inuit, and Métis. Other affiliated members may include non-Indigenous members.

The Advisory Circle shall have at least 8 members and no more than 12 members including the Advisory Circle Keeper.

When considering Advisory Circle membership, CPSM Council and the Advisory Circle Keeper must ensure, as reasonably possible, that it reflects the diversity of Manitoba's First Nation, Inuit, and Métis population.

Support will be provided from the CPSM Staff.

COUNCIL MEETING
SEPTEMBER 23, 2026
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Registration Policies**

Purpose:

To approve the Board of Assessors' proposed amendments to CPSM Council Policies:

1. Registration of Clinical and Physician Assistants and Physician Assistant Students;
2. Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes;
3. Registration in the Provisional Specialty Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes

The Board of Assessors' Terms of Reference state:

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

1. Amendment to the Council Policy for Registration of Clinical and Physician Assistants and Physician Assistant Students

Two proposed amendments for this Policy in **clause 10.2.1.2**.:

- The amendment at clause **i)** would expand our recognition of Canadian clinical fellowship training beyond just programs accredited by the RCPSC.
- The amendment at clause **ii)** would allow the Registrar to approve assessments conducted by Manitoba faculty affiliated Departmental and Program settings. Most often, these are designed to assess candidates' ability to function in very specific practice areas and settings. Candidates are often from other health professions, for example nursing.

Tracked changes of this Policy is attached as ***Appendix A***.

2. Amendment to Council Policy for Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes

Three proposed amendments for this Policy are:

- **Section 1.1** - Adds approved jurisdiction registration to the list of full-licensure pathways not met by some candidates. This is to align with recent regulatory changes.
- **Section 1.3** - Satisfactory postgraduate clinical training when applying for provisional family practice registration:
    - Clarifies that training must support certification or authorization as applicable to the specific training program in the relevant jurisdiction and adds wording to the effect that incomplete training or training that does not contribute to certification/authorization will not be accepted.
    - Adds or refines timing language for required rotations, including that rotations must be completed within a five-year period.
- **Section 2.3** - Time limited registration
    - Changes the assessment candidate registration period from three months to 12 months. Updates the related extension language from a three-month period to a twelve-month period. This is to align with recent legislative changes.

The Policy is attached as ***Appendix B***. Changes are tracked for the Committee's review.

3. Amendment to Council Policy for Registration in the Provisional Specialty Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes

There are numerous tracked changes in the Policy:

- **Section 1.4.1.5.** - Added clarity that Royal College-accredited Canadian residency and fellowship training programs may count as satisfactory completion of an approved assessment.
- **Section 1.4.1.6.** - This section is deleted and replaced with amendments that:
    - Expand and better clarify the pathway for non–Royal College-accredited fellowship training completed at a Canadian university teaching hospital. The new language requires successful completion, a formal assessment component, and Registrar satisfaction that the assessment is substantially equivalent in rigor and scope to relevant PRA-SP components.
    - Added Registrar discretion where fellowship assessment is only partially equivalent. The Registrar may approve a partial PRA-SP assessment limited to unassessed competencies or approve provisional registration with a restricted scope of practice.
    - Added safeguards for restricted-scope registration. The Registrar must be satisfied the applicant can safely and competently practise across the relevant patient population and care spectrum. Any scope limitation must be clearly defined, proportionate, and directly linked to patient safety. Of note, this aligns with our MPAP (Manitoba Practice Assessment Program policy).
- **Section 1.5.2.** - Change to reflect a change in the regulatory requirement that provisional specialty practice-limited registrants work toward full registration by obtaining Royal College certification, completing an approved supervised practice period tied to affiliate

status, or obtaining a successful MPAP designation. This is to align with amendments to the regulation.

- **Section 2.2.** and **2.3.** - The list of approved specialty fields is now tied to the attached "List of Approved Fields of Specialty Practice for Assessment," rather than being described as fields approved by the Manitoba Faculty's IMG Program and updated by the faculty. This change means that CPSM will need to approve all new fields in which a PRA can be performed.

The Policy is attached as ***Appendix C***. Changes are tracked for the Committee's review.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

Council approve the attached proposed amendments to Council Policies:

- Registration of Clinical and Physician Assistants and Physician Assistant Students;
- Registration in the Provisional Family Practice-Limited, Assessment Candidate (Family Practice), and Provisional (Non-Practicing) Classes;
- Registration in the Provisional Specialty Practice-Limited, Assessment Candidate Specialty Practice, and Provisional Non-Practicing Classes

Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation

COUNCIL POLICY

Registration of Clinical and Physician Assistants and Physician Assistant Students

Initial Approval: March 20, 2024

Effective Date: March 20, 2024; March 18, 2026

Reviewed with No Changes:

Reviewed with Changes:

PREAMBLE:

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

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

[1] See s. 2.4 of the *CPSM General Regulation*.

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

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

Specific provisions of the *CPSM General Regulation* that apply to ClA, PA and PA Student classes of registration are reproduced in this Policy for ease of reference. The purpose of this Policy is to set out additional registration requirements that have been approved by Council. This Policy only relates to the issuance of certificates of registration. It does not deal with the requirements for certificates of practice listed at Part 4 of the *CPSM General Regulation*.[5] Certificates of practice and other practice requirements for ClAs, PAs, and PA Student are also addressed in the 'Practice and Supervision Requirements for ClAs, PAs, and PA Students' Practice Direction and at Part 8 of the *CPSM General Regulation*.

1. APPLICABLE PRACTICE LIMITATIONS

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

1.1.1. Part 8 of the *CPSM General Regulation* concerning practice description and contract of supervision requirements for PAs and ClAs,[6]

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

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

1.2. PA Students do not require a practice description and contract of supervision. Their scope of practice is limited to practice under the supervision of the teaching staff in a particular department or departments of their educational program. Other conditions may be imposed, depending upon the circumstances. Sections 5.18, 5.19 and 5.20 of the *CPSM General Regulation* limit the performance of reserved acts by all students, including PA Students. Further information about the practice of PA Students is provided in the attached contextual information document.

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[2] The RHPA at s. 33 states, "*an application for registration as a regulated associate member must be considered and decided upon in accordance with the regulations.*"

[3] As an exception, an applicant for registration in the Physician Assistant (Academic — Section 181 Faculty) Class must provide satisfactory evidence that they meet the requirements at s. 181(1)(b) of the RHPA.

[4] See s. 3.2(1) of the *CPSM General Regulation* at point 9(b).

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

[6] See also the 'Practice Direction Practice and Supervision Requirements for ClAs, PAs, and PA Students'.

2. EDUCATIONAL (PHYSICIAN ASSISTANT STUDENT) CLASS

2.1. Specific requirements for registration:

2.1.1. This class is established for the registration of PA Students. The specific requirements for the Educational (Physician Assistant Student) Class are set out at section 3.50 of the *CPSM General Regulation*:

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

2.2. Terms and Conditions on registration:

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

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

2.3. Cancellation of Registration:

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

3. EDUCATIONAL (EXTERNAL OR VISITING STUDENT) CLASS

3.1. Specific requirements for registration:

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

3.1.1.1. submit a signed application in the approved form,

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

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

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

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

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

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

3.2. Approved PA training programs located outside of Manitoba:

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

3.2.1.1. the Canadian Armed Forces,

3.2.1.2. University of Toronto,

3.2.1.3. McMaster University,

3.2.1.4. a university-affiliated program in Canada satisfactory to the Board of Assessors, and

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

3.3. Terms and conditions on registration:

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

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

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

3.4. Cancellation of registration:

3.4.1. In accordance with section 3.93 of the *CPSM General Regulation*, an external or visiting PA Student's registration is cancelled if they cease to be enrolled with the Physician Assistant Education Program or the specified period for which the registration was issued expires.

4. EDUCATIONAL (NON-PRACTICING) CLASS

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

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

5. PHYSICIAN ASSISTANT (FULL) CLASS

5.1. Specific requirements for registration:

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

3.61 An applicant for registration as a physician assistant (full) member must

(a) establish that he or she has satisfactorily completed an approved clinical training program; and

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

(i) he or she is a graduate of the Physician Assistant Education Program at the Manitoba faculty,

(ii) he or she

(A) is a graduate of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in the United States,

(B) has passed the examination set by the NCCPA, and

(C) holds the designation "PA-C",[7] [or]

(iii) he or she is a graduate of another approved physician assistant training program.

5.2. Examinations required by Council:

5.2.1. In accordance with subsection 3.37(a) of the *CPSM General Regulation*, Council requires that the applicant must have passed one of the following examinations to be initially registered in the Physician Assistant (Full) Practicing Class:[8]

5.2.1.1. the Physician Assistant Entry to Practice Certification Examination ("PA Certification Examination")[9], or

5.2.1.2. the examination set by the NCCPA.

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

[8] Council does not expressly require PAs to hold the PA-C or CCPA designation to maintain registration. However, it is recognized this may be needed to meet CPSM's continuing competency requirements under Part 10 of the *CPSM General Regulation*.

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

5.3. PA training programs approved by Council:

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

5.3.1.1. the Canadian Armed Forces,

5.3.1.2. University of Toronto,

5.3.1.3. McMaster University, and

5.3.1.4. a university-affiliated program in Canada satisfactory to the Board of Assessors.

6. PHYSICIAN ASSISTANT (RESTRICTED PURPOSE) CLASS

6.1. Specific requirements for registration:

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

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

> *3.62 An applicant for registration as a physician assistant (restricted purpose) member must*
>
> *(a) establish that he or she is authorized to practise medicine as a physician assistant in another jurisdiction in Canada or elsewhere and is in good standing in that jurisdiction;*
>
> *(b) submit to the registrar a signed declaration that he or she will engage in the practice of medicine only for one or more of the following purposes:*
>
> *(i) to provide medical services on a temporary basis at a specified location or facility,*
>
> *(ii) to conduct a training course or clinical presentation related to his or her professional practice,*
>
> *(iii) to conduct or engage in a research program related to his or her professional practice,*
>
> *(iv) to demonstrate equipment or techniques to be used in clinical care related to his or her professional practice,*
>
> *(v) to provide medical services during a public health emergency as authorized under subsection 56(1) of the Act,*
>
> *(vi) for any other approved purpose; and*

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

6.2. Terms and conditions on registration:

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

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

6.3. Cancellation of registration:

6.3.1. Cancellation will occur on the earliest of:

6.3.1.1. expiry of the specified period of registration,

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

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

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

7.1. Specific requirements for registration:

7.1.1. Section 181 of the RHPA requires CPSM register PAs in the Physician Assistant (Academic – S. 181 Faculty) Class based on a certificate from the Manitoba Faculty when the requirements of that section are met.[10] Section 181 states:

181(1) The registrar must approve an application for registration

…

(b) as a regulated associate member, if the applicant

(i) is granted a certificate by the university in accordance with subsection (2), and

(ii) meets the requirements set out in the regulations.

181(2) The university may grant a certificate under the academic seal of the university to an applicant who meets both of the following requirements:

(a) the applicant is a full-time member of the Faculty of Medicine;

[10] When registration occurs under this section, the usual common requirements, and non-exemptible requirements under *the CPSM General Regulation* are abrogated.

(b) the applicant provides evidence to the university's satisfaction that he or she has passed any examinations required by the university and has met any other requirements of the university.

181(3) A registration may be subject to any conditions that the registrar considers advisable.

7.1.2. Section 3.64 of the *CPSM General Regulation* lists other specific requirements for registration in the Physician Assistant (Academic – S. 181 Faculty) Class:

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

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

(i) a confirmation that the applicant is or will be legally entitled to work or study in Manitoba before engaging in his or her professional practice,

(ii) a confirmation that the applicant meets the approved English language fluency criteria,

(iii) a description of the applicant's most recent professional practice and proposed professional practice; and

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

7.2. Terms and conditions:

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

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

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

7.3. Cancellation

7.3.1. The Physician Assistant (academic – s. 181 faculty) Class registrant’s membership is cancelled if the member’s s. 181 certificate is revoked or lapses.

8. PHYSICIAN ASSISTANT (NON-PRACTICING) CLASS

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

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

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

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

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

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

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

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

9. RETIRED (PHYSICIAN ASSISTANT) CLASS

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

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

10. CLINICAL ASSISTANT (FULL) CLASS

10.1. Specific requirements for registration:

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

> *3.67 An applicant for registration as a clinical assistant (full) member must*
> *(a) complete an approved assessment; and*
> *(b) establish that he or she meets one of the following criteria:*
> *(i) he or she holds*
> *(A) a degree in medicine granted from a nationally approved faculty of medicine, or*
> *(B) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation,*
> *(ii) he or she is a graduate of an approved and accredited physician assistant or clinical assistant training program that is restricted to a field of practice,*
> *(iii) he or she is a member in good standing of a regulated health profession in Manitoba,* [or]
> *(iv) he or she is certified in the highest level of emergency medical attendant certification at the time of application.*

10.2. Approved Assessments for ClAs:

10.2.1. ClA assessments approved by Council for the purposes of ss. 3.67(a) of the *CPSM General Regulation* are as follows:
10.2.1.1. For ClAs with no field of practice restriction on their registration:

i. Registered Clinical Assistant Assessment offered by the Manitoba faculty.[11]
ii. National Assessment Collaborative OSCE (NAC-OSCE).
iii. Successful completion of the MCCQE1.

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

i. Satisfactory completion of a clinical fellowship program ~~program accredited by the Royal College of Physicians and Surgeons of Canada~~ in a Canadian University teaching hospital in the applicant's intended field of practice.
ii. Satisfactory completion of an assessment that must be pre-approved by the Registrar and that is conducted in a Manitoba faculty affiliated Departmental or Program setting.

11. CLINICAL ASSISTANT (NON-PRACTICING) CLASS

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

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

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

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

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

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

[11] The Clinical Assistant Assessment is no longer being conducted by the Manitoba faculty, though candidates assessed under the program in the past will still be eligible for registration.

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

12. RETIRED (CLINICAL ASSISTANT) CLASS

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

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

COUNCIL POLICY

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

Initial Approval: March 19, 2025 | **Effective Date: March 19, 2025**

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Contents

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, approved jurisdiction registration, 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. In considering whether the family medicine clinical training requirements at subsections 3.19(1)(b)(iv) or (v) are met, the Registrar will compare the applicant's training experience against the Canadian standard as a reference.[5]

1.3.2. Training must have taken place in one or more facilities that
- provide health care,
- are recognized by a national post-graduate training authority,
- was accredited with a national post-graduate training authority at the time of training, and
- is approved by the registrar.

1.3.3. The training must be recognized in the jurisdiction where it took place as sufficient for certification or authorization to practice as a general practitioner or family physician, whichever is applicable to the specific training program. For greater clarity, incomplete training or training that does not contribute to certification, or authorization will not be accepted.

~~1.3.3.~~1.3.4. At a minimum, training must include rotations of at least 8 weeks duration in medicine[6], obstetrics and gynecology and pediatrics[7], and at least 4 weeks in surgery (as needed for procedural skills). CPSM may accept

[5] Post-graduate medical education (PGME) in family medicine in Canada is designed to prepare residents to provide comprehensive, patient-centered primary care. The goal is to provisionally license family physicians that will be able to go to obtain certification from the CFPC.
[6] This is interpreted to include rotations in general medicine, medicine, or internal medicine. Up to 4 weeks of this period can be medicine related subspecialties, for example respirology, cardiology, hepatology, infectious disease, nephrology, etc.).
[7] This is interpreted to include pediatric emergency medicine.

clinical rotations that take place as part of an internship program following undergraduate medical education. Rotations must be taken within 5 years of each other, collectively.

~~1.3.4.~~1.3.5. Rotations in areas including psychiatry, emergency medicine, and geriatrics are desirable, but do not substitute for the required rotations.

~~1.3.5.~~1.3.6. Only in-person, full-time training will qualify.

~~1.3.6.~~1.3.7. For the purposes of subsection 3.19(1)(b)(iv), successful completion of the twelve (12) month Manitoba Licensure Program for International Medical Graduates (MLPIMG) will count toward one year of clinical training experience.

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

1.4.1. For the purposes of subsection 3.19(1)(b)(v), practice experience in family medicine must be:
1.4.1.1. independent practice experience,
1.4.1.2. in general practice, family medicine, or primary care as a physician, and
1.4.1.3. equal to or greater than seventy (70) percent in-person care (a minority of practice may be virtual).

1.4.2. Postgraduate training (internship/residency) does not count towards the practice experience requirement and vice versa.

1.4.3. Independent practice requires a license to practice independently in the applicable jurisdiction and the authority to act as the most responsible physician for patient care.

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.[8]

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

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.[9]

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:[10]

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*

[9] 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.

[10] 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.

> *(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*
>
> *(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 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.[11]

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.

[11] 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.

CPSM will accept applications for the PRA-FP and will review the applicant's training and practice experience. Candidates who meet the eligibility requirements will be referred to the IMG Program for the next stage of the selection process.

2.3. Time limited registration

2.3.1. 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~~ 12 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.

2.3.2. Under section 3.71 of the *CPSM General Regulation*, the Registrar may extend the usual ~~three~~ twelve (~~3~~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.

2.3.3. 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:

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

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

2.3.4. 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.

2.4. Terms and conditions

2.4.1. Registration in this class is restricted to a specific practice setting and professional practice and may be subject to having to do orientation.[12] 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.

[12] 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.

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.

2.5. Conversion to provisional registration

2.5.1. 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.

2.6. Cancellation

2.6.1. 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.

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 (family 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 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**

Reviewed with changes: March 19, 2025

Contents

PREAMBLE:

This Policy relates to registration in the following classes:

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

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

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

1. Provisional (specialty practice-limited) class

1.1. Purpose and overview

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

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

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

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

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

[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.

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. This includes both accredited residency and fellowship training programs.

~~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.~~

1.4.1.6. Satisfactory completion of a fellowship training program that is not accredited by the Royal College, provided that all of the following requirements are met:

1. the fellowship training has been successfully completed by the applicant;
2. the fellowship training took place at a Canadian university teaching hospital;
3. the fellowship training included a formal assessment component; and
4. the Registrar is satisfied that the assessment components of the fellowship training are substantially equivalent, in respect of assessment rigor and scope, to the relevant assessment components of the PRA-SP.

[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.

Where the Registrar determines that the assessment components of the fellowship training do not fully demonstrate equivalence with the assessment components of the PRA-SP, the Registrar may, in their discretion:

1. approve a partial assessment under the PRA-SP, the scope of which is limited to those competencies that were not adequately assessed during the fellowship training; or
2. approve registration in the provisional (specialty practice limited) class with terms and conditions restricting the scope of practice to those areas that were satisfactorily assessed as part of the fellowship training.

Registration with a restricted scope may only be approved where the Registrar is satisfied that the applicant can safely and competently practise across:

1. the full spectrum of medical care required for the identified patient population; and
2. the entire patient population ordinarily served within the restricted area of practice.

Any scope limitation imposed under this clause must be clearly defined, proportionate to the demonstrated competencies, and directly linked to patient safety considerations.

The onus to demonstrate the requirements of this clause is on the applicant. Information from the relevant Program Director, Specialty-Lead, the PRA-SP Program Director, or others as directed by the Registrar, may be required.

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:

(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. 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

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

- 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.

1.4.4. 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 (specialty practice-limited) class registration. However, they may be eligible for registration in the assessment candidate (specialty practice) class for the purpose of undergoing an Approved Assessment (see section 3.38 of the *CPSM General Regulation*).

1.4.5. 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:

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

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

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

1.4.6. 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*
>
> *(a) obtaining Royal College certification in a specialty field of practice;*
>
> *(a.1) satisfactorily completing an approved period of supervised practice as a holder of affiliate status with the Royal College in a subspecialty; or*
>
> *(b) obtaining the designation of "successful in the MPAP" in the area in which he or she is assessed*

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

1.6. Extension of provisional registration

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

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

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

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

1.6.3. Sections 3.72 and 3.73 CPSM of the *CPSM General Regulation* require that the Registrar provide written reasons for their approval or refusal of the

extension and, if the Registrar does not grant an extension, the applicant has a right of appeal.

1.7. Conversion to another class

1.7.1. Registration in the provisional (specialty practice-limited) class is limited to a five (5) year period, plus any extension granted by the Registrar. By the end of that period, to maintain registration, the member must covert to another class for which they are eligible, for example the provisional (MPAP) class or the full (practicing) class. Members in the provisional (specialty practice-limited) class may also be converted to the provisional (non-practicing) class in certain specified circumstances. Conversion is governed by sections 3.74 and 3.75 of the *CPSM General Regulation*, which provide:

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

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

1.8. Cancellation

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

3.84(1) The registration of a provisional (specialty practice-limited) member … is cancelled on the earliest occurrence of the following:

(a) the ministerial certificate is revoked or lapses;

(b) the member is no longer eligible for the Medical Council of Canada examination for cause;

(c) the member's certification by the Royal College, American Board of Medical Specialties, or CFPC, as the case may be, is revoked for cause;

(d) the specified or extended membership period ends;

(e) the member receives the designation of "unsuccessful in the MPAP";

(f) the member ceases to practise in Manitoba.

3.84(2) A person whose registration is cancelled under clause (1)(d) or (e) may apply for registration only as a regulated associate member in one of the following classes:

(a) educational (medical student);

(b) educational (physician assistant);

(c) educational (resident);

(d) clinical assistant (full)

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

~~2.~~ Assessment candidate (specialty practice) class

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

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

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

~~..~~2.1. Specific requirements under the *CPSM General Regulation*

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

3.38 The registrar may register an applicant in the assessment candidate (specialty practice) class if the applicant

(a) establishes that he or she meets the requirements for registration as a provisional (specialty practice-limited) member in subsection 3.16(1) other than the requirements to

(i) enter into a satisfactory arrangement with a practice supervisor under clause 3.16(1)(f), and

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

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

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

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

~~..~~2.2. Specialty fields of practice approved for this class

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

~~..~~2.3. Accepted into an approved assessment

~~...~~2.3.1. Council has approved the Practice Ready 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 in fields of practice that are approved by the Registrar under this Policy in accordance with parameters established by Council.

[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.

2.3.2. 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.

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
SEPTEMBER 23, 2026
MOTION FOR APPROVAL BRIEFING NOTE

SUBJECT: **International Medical Graduate Working Group Final Report**

Purpose:

The International Medical Graduate (IMG) Working Group submits its final report for Council. The Report (***see Appendix A***) includes the results of the IMG Working Group survey, findings from related consultations and focus groups, a summary of initiatives undertaken by the Working Group, and recommendations for future action. The quantitative and qualitative analysis of survey data was prepared by Dr. Ada Man.

Dr. Man will present her analysis in person to Council.

Background:

The IMG Working Group was established to examine issues affecting International Medical Graduates (IMGs) and Internationally Trained Physicians (ITPs) entering the Manitoba practice environment. The Working Group's mandate focused on identifying barriers to successful integration, enhancing supports available to entering physicians, and recommending measures to improve orientation, education, mentorship, and transition to practice.

The Working Group was specifically tasked with examining:

- How CPSM can better support integration of IMGs and ITPs into the Manitoba health system;
- How gaps in education, training, and orientation can be identified and addressed;
- What supports and resources are required to facilitate successful transition into practice; and
- What behaviours and professional expectations should be fostered to support long-term success within the profession.

IMG Working Group Survey:

A major component of the Working Group's work was the development and administration of a province-wide survey of CPSM registrants. The survey was designed to compare the experiences of IMGs, ITPs, and Canadian-trained physicians entering and establishing practice in Manitoba. It examined registration and assessment pathways, orientation needs, integration into practice settings and communities, discrimination and harassment, mentorship, workplace culture, satisfaction, and retention-related factors.

The survey was distributed to all CPSM registrants and received 299 responses, including 190 IMG respondents and 109 Canadian-trained physician respondents.

Analysis of responses suggests several recurring themes:

- Strong support for enhanced orientation and onboarding resources;
- Significant interest in mentorship and transition-to-practice supports;
- Challenges navigating Manitoba's health system and workplace culture;
- Experiences of discrimination, bias, and inequitable treatment reported by some IMGs;
- Desire for clearer information regarding licensure pathways and expectations;
- Recognition that successful integration depends on both the entering physician and the practice environment receiving them.

The final report provides both quantitative and qualitative analyses of these findings, including comparative results between IMG and non-IMG respondents and thematic review of free-text submissions.

Work Completed by the Working Group:

In addition to the survey, the Working Group has contributed to the development of several initiatives intended to improve support for physicians entering the Manitoba practice environment. These include:

1. Orientation Program - The Working Group played a significant role in the design of CPSM's physician orientation program. Topics identified by the Working Group include:
   - CPSM's regulatory framework and expectations;
   - Manitoba's health-care system;
   - Cultural safety and anti-racism principles;
   - Indigenous health and reconciliation;
   - Communication and professionalism;
   - Documentation and patient records;
   - Workplace culture and team-based practice environments.

2. Standard of Practice - The Working Group also provided input into the development of a proposed Standard of Practice relating to entering a new practice environment in Manitoba. This work was informed by focus group discussions, survey responses, and partner engagement.

3. Educational Resources - The Working Group explored opportunities to improve educational materials available to physicians entering practice, including guidance for IMGs, supervisors, mentors, and receiving practice environments. Information is included as part of the Contextual Information along with the Standard of Practice.

Report Recommendations:

The report contains recommendations in several broad areas:

1. Orientation and Transition Supports - Recommendations respecting continued delivery and enhancement of orientation programming for physicians entering the Manitoba practice environment, including CPSM's own offerings.

2. Mentorship and Professional Integration - Recommendations aimed at improving access to formal and informal mentorship opportunities and strengthening workplace integration supports.

3. Cultural Safety and Professional Conduct - Recommendations regarding cultural humility, anti-discrimination initiatives, respectful workplace expectations, and professional accountability. Survey respondents identified discrimination, workplace culture, and reporting mechanisms as important areas requiring ongoing attention.

4. Information and Resources - Recommendations regarding improved access to information about physician licensure pathways, practice expectations, navigation of health systems, and available supports.

5. Ongoing Monitoring - Recommendations respecting future data collection, evaluation, and monitoring to assess whether initiatives undertaken by CPSM improve transition-to-practice experiences and retention of physicians in Manitoba.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

The Final Report of the IMG Working Group be accepted as presented.

Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation

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Report to Council on the IMG Working Group (2024 – 2026)

Supporting International Medical Graduates and Internationally Trained Physicians Entering Practice in Manitoba

Prepared by
Mr. Jeremy de Jong, JD
College of Physicians and Surgeons of Manitoba
and
Dr. Ada Man, MD, FRCPC

August 20, 2026

Contents

Executive Summary

Internationally Trained Physicians (ITPs) and International Medical Graduates (IMGs) are an essential part of Canada's physician workforce and play a particularly important role in sustaining access to care in Manitoba, including in rural, remote, and underserved communities. At the same time, evidence reviewed by CPSM and the experiences shared by Manitoba physicians show that ITPs and IMGs have often faced significant barriers when seeking registration and licensure, transitioning into practice, and remaining in Manitoba over the long term. CPSM established the IMG Working Group in 2024 to better understand these complex issues and to identify practical regulatory responses that would support improvements, including to ensure safe, fair, and effective entry into practice in Manitoba.

Mandate: The Working Group's mandate was grounded in CPSM's public-interest responsibility and its obligations related to patient safety, fair registration practices, and the need to promote respectful, culturally safe, and supportive practice environments. It was also grounded in CPSM's legislated mandate to work in consultation with government towards achieving access for the people of Manitoba to adequate numbers of qualified and competent medical practitioners. The Working Groups Terms of Reference are included at **Appendix A**.

The Working Group completed five interconnected streams of work over a two-year period under the mantra of moving from problem identification to practical regulatory action. It reviewed relevant literature and publications, held focus groups with IMGs and ITPs practicing in Manitoba, developed and administered a survey of CPSM registrants, supported the development of a new orientation program, and developed a Standard of Practice for Entering Practice in Manitoba. Together, these activities provided CPSM with a stronger understanding of the barriers experienced by ITPs and IMGs as well as the supports needed to improve integration, retention, and professional practice, and represented first steps in making necessary improvements.

Deliverables: A detailed analysis of survey results prepared by Dr. Ada Man is provided at **Part II** of this report. The new orientation program and Standard of Practice are described at **Part III**. The new Standard of Practice for Entering Practice in Manitoba and related Contextual Information is attached as **Appendix B**. Recommendations are at **Part IV**.

Registration and licensing: ITPs and IMGs bring substantial prior training and experience, but many encounter complex registration pathways, limited access to practice-ready assessments (PRAs) or post-graduate training opportunities, and variable mentorship and supervision experiences. These findings signal a need for clearer information about registration pathways, an evidence-informed review of existing requirements, efficiency and simplification where appropriate, and improved mentorship and supervision supports for those entering practice. Findings also support continuing our work to modernize licensure pathways to better enable recognition of demonstrated competencies, remove unnecessary barriers, and accommodate differing scopes of practice, all while ensuring safe integration into Manitoba's healthcare system.

Orientation and onboarding: Survey respondents across the board reported inconsistent onboarding and orientation to their practice settings. Findings revealed a strong interest in having practical support to help better understand the Manitoba health system, CPSM's regulatory expectations, local clinical workflows, prescribing and documentation practices, referral and transfer processes, billing and practice models, and professional expectations related to self-regulation, reporting, complaints processes, and continuing professional development.

Community integration: Survey respondents signalled a significant desire for community and system orientation. The Working Group heard evidence that workplace culture is a significant factor in successful transition to practice. Many physicians described the value of supportive colleagues, mentorship, constructive feedback, and clear expectations. On the negative side, survey and focus group results identified challenges with working conditions and misalignments between training and job demands and concerning experiences of discrimination, racism, differential treatment, harassment, unclear reporting pathways in the transition period.

The literature review as well as focus group and survey findings indicate that successful integration cannot be understood only as an individual registrant's responsibility; it also depends on the practice environment, leadership, team culture, the availability of safe and effective supports, and an **approachable and trusted regulatory environment**.

In response to what was learned: A new orientation program was developed for physicians entering practice in Manitoba, which was first delivered in January 2026. The orientation was designed to provide practical, system-specific information and to support safer and more confident entry into practice. Its content was shaped by the Working Group's evidence and includes Manitoba's health system, CPSM's role, standards and practice directions, complaints and duty-to-report obligations, cultural safety and reconciliation, interprofessional communication, prescribing, documentation, referrals, billing and practice models, physician wellness supports, and other topics identified as important to an effective transition into practice.

A new Standard of Practice for Entering Practice in Manitoba has been developed and was approved by Council on June 24, 2026 - with an effective date of October 1, 2026. The Standard clarifies expectations for registrants entering practice and for the registrants, physician leaders, and teams receiving them during this critical transition period. It emphasizes respectful interprofessional relationships, orientation, supervision, mentorship, feedback, cultural safety, anti-racism, wellness, and psychologically safe practice environments. This content reflected the Working Group's conclusion that successful transition to practice is a shared responsibility.

This report concludes with recommended next steps, including for the maintenance and evaluation of the orientation program, implementation of the Standard of Practice, development of plain-language regulatory resources, supporting onboarding and mentorship expectations, improved data collection, continued engagement with ITPs and IMGs, and collaboration with health-system partners to address system adaptability, workplace culture, reporting, discrimination, and retention.

IMGs and ITPs:

For the purposes of this report, the terms International Medical Graduate (IMG) and Internationally Trained Physician (ITP) are used to describe medical doctors whose undergraduate medical education or postgraduate training occurred outside Canada. These terms are sometimes used differently across organizations. In practice, they include both medical graduates who immigrated to Canada after education and training abroad and Canadians who completed medical education outside Canada before returning to seek training or licensure.

The common feature for IMGs and ITPs is that they often enter Canadian practice through additional training, assessment, registration, or orientation processes that differ from those experienced by medical doctors who completed their undergraduate medical education or postgraduate training in Canada. However, this is otherwise a highly heterogenous group.

The terms IMG and ITP do not capture the wide variation in career stage, specialty, scope of practice, jurisdiction of training, clinical experience, language and cultural background, familiarity with Canadian systems, immigration and settlement circumstances, or registration pathway. Some are recent graduates seeking postgraduate training, while others are experienced independently practicing physicians with years of specialist or generalist practice (this group is more aptly described as ITPs[1]). Some trained in systems closely aligned with Canadian expectations, while others come from systems with different regulatory structures, clinical workflows, resources, disease burdens, and communication norms.

For the purposes of this report, it important to consider that the diversity among IMGs and ITPs means that registration pathways and supports for practice should not assume a single IMG or ITP experience; rather, they should be flexible enough to recognize prior competence, identify genuine transition needs, and support safe integration into Manitoba practice.

[1] Note: In Manitoba, the 'Physician' title may only be used by Regulated Registrants, Residents, and Assessment Candidates pursuant to Part 6 of the *CPSM General Regulation*.

Acknowledgements

CPSM gratefully acknowledges the members of the IMG Working Group for their time, expertise, and thoughtful contributions to this work. The Working Group brought together regulatory, clinical, operational, and lived-experience perspectives to better understand the experiences of IMGs and ITPs entering and establishing practice in Manitoba. Their guidance was central to the development of the orientation program, the proposed Standard of Practice, and the recommendations contained in this report:

- **Dr. Nader Shenouda**, Working Group Chair, CPSM President, Registrant
- **Mr. Jeremy de Jong**, CPSM Legal Counsel
- **Ms. Wendy Elias-Gagnon,** CPSM Communications Director
- **Dr. Sonja Bruin**, CPSM Assistant Registrar, Registrant
- **Dr. Martina Reslerova**, University of Manitoba, Registrant
- **Dr. Zheng Xi,** University of Manitoba, Registrant
- **Dr. Karen Appel,** Manitoba College of Family Physicians, Registrant
- **Dr. Ganesan Abbu,** Registrant
- **Dr. Rafiq Andani**, Registrant
- **Dr. Jocelyn Dumatol-Sanchez**, Registrant
- **Dr. Shadi Rezazadeh**, Registrant
- **Dr. Nicole Vosters**, Registrant
- **Mr. Ziad Khaled**, Registrant
- **Ms. Stacey Soldier**, Public Representative, Lawyer
- **Ms. Clara Weiss**, Shared Health
- **Ms. Jennifer MacDonald**, Doctors Manitoba
- **Mr. Sean Brygidyr,** Manitoba Health
- **Ms. Lisa Goss,** Manitoba College of Family Physicians

A special thanks is offered to the Chair of the Working Group, Dr. Nader Shenouda, whose dedication, commitment, and tireless efforts were central to the Working Group's success. Dr. Shenouda provided thoughtful guidance throughout this work, helped ensure that the voices and experiences of IMGs and ITPs remained at the centre of the Group's discussions.

CPSM also recognizes the physicians who participated in the focus groups and shared their experiences with honesty and care. Their contributions provided the Working Group with important insight into the barriers, supports, and practice-environment factors that affect IMGs and ITPs in Manitoba. The report is stronger because of their willingness to describe both the challenges they encountered and the supports that helped them succeed. Note, these members are not named as participation in focus groups was confidential. CPSM also acknowledges the registrants who completed the survey and contributed their perspectives integration, workplace culture, and the supports needed for physicians entering practice in Manitoba.

CPSM gratefully acknowledges Dr. Ada Man for her detailed analysis of the survey data, which provided an important evidence base for the Working Group's findings and recommendations.

Part I - Introduction and context

Part I of this report provides the background and context for the IMG Working Group's work, including the reasons the Working Group was established, the registration and workforce landscape for IMGs and ITPs in Manitoba, relevant literature and reports, and the focus group themes that helped shape the Working Group's priorities. Readers who wish to move directly to the Working Group's concrete outputs may proceed to Part II for the survey analysis, Part III for the orientation program, Standard of Practice, and related regulatory initiatives, and Part IV for the Working Group's recommendations.

Establishment of the IMG Working

CPSM established the IMG Working Group in 2024 in response to evidence of need, including persistent concerns about the experiences of IMGs and ITPs entering and integrating into medical practice in Manitoba.

Concerns raised by IMGs and ITPs include the complexity of registration and assessment pathways, inconsistent access to orientation and mentorship, uncertainty about local practice expectations, and broader challenges related to workplace culture, discrimination, racism, and professional integration. In its own processes, CPSM observed instances of care or professionalism lapses or pitfalls that were thought to be reasonably preventable through appropriate preventative measures like meaningful orientation and connection with resources. Numerous recent publications echoed these areas of concern in other provinces.

The concerns and challenges described by IMGs and ITPs are not surprising. They often enter practice while adapting to a new regulatory framework, a new health-system structures, new professional norms, and new professional expectations related to documentation, prescribing, referral processes, communication, reporting, complaints, cultural safety, and self-regulation. This comes with significant personal and professional burdens, engaging important wellness considerations.

The Working Group's Terms of Reference identified a practical and strategic mandate to address the above issues.

The Working Group's primary purpose was to assist in the development and establishment of a new CPSM-led orientation program for IMGs and ITPs entering or maintaining practice in Manitoba. This included reviewing the current issues experienced by IMGs and ITPs, identifying the supports needed for safer and more effective transition into practice, and ensuring that the orientation program reflected the practical realities of Manitoba's health system and practice environments. But this was only one component of what needs to be a larger effort.

The Working Group was also asked to develop and recommend a new Standard of Practice addressing physicians entering a new practice environment. This component of the mandate reflected the view that successful integration is a shared responsibility. Registrants entering

practice must understand and meet professional and regulatory expectations, while physicians, leaders, and teams receiving new colleagues must provide clear expectations, including regarding roles and responsibilities, constructive feedback, respectful interprofessional relationships, and appropriate orientation, supervision, mentorship, and support.

The Terms of Reference for the Working Group included making broader recommendations related to registration policies and processes affecting IMGs and ITPs, CPSM's obligations under fair registration legislation, and the adequacy of mentorship and supports, and orientation expectations in systems and practice settings.

The Working Group's mandate aligned with CPSM's commitments related to equity, cultural safety, and Truth and Reconciliation. A fair pathway into practice requires supports that allow all registrants to understand and meet these expectations. Commitments to cultural safety and reconciliation with Indigenous peoples require attention to the practice environment into which registrants are entering, including how they communicate with patients, work with Indigenous patients and communities, and model respectful relationships with colleagues and teams. This aspect of the mandate was to inform all aspects of the Workgroup Group's efforts.

On a final note, it was recognized that ITPs may come with deeply held negative perceptions of government or regulatory authorities based on negative experiences in jurisdictions where they trained or practiced previously, which could potentially impede them from seeking help or guidance from CPSM or within their practice settings. The Working Group was therefore asked to focus on enhanced means of relationship-building with newly licensed physicians as part of making this project successful in the long term.

The establishment of the Working Group marked an important and proactive shift in focus. Rather than treating registration, orientation, workplace culture, and retention as separate issues, the Working Group considered them as connected parts of the same transition-to-practice challenge. Its work was intended to ensure that Manitoba can welcome and support internationally trained medical professionals in a way that is fair, responsive to workforce needs, protective of patients, and consistent with CPSM's regulatory responsibilities.

Registration pathways and workforce data

Barriers to registration and licensure:

Notwithstanding physician shortages in Canada and the importance of IMGs and ITPS to our workforce, numerous studies have highlighted barriers to their registration and licensure that may not always be necessary, efficient, or competency or safety oriented. Evidence further shows that many IMGs and ITPs remain underutilized because of limited training and assessment capacity. Canadian policy literature has described the ITP pathway as complex, expensive, province-specific, and difficult to navigate, with information that may be fragmented, unclear, or inconsistent across immigration, licensure, and employment steps.[2]

For context, depending on their level of training, certification, specialty, practice history, and jurisdiction of origin, ITPs may be required to complete additional examinations, language testing, residency training, a practice-ready assessment (PRA) or other workplace-based assessment, supervision, and other regulatory requirements. Many IMGs and ITPs must compete for a limited number of residency positions and PRA opportunities.

Recent commentary in The Lancet Regional Health – Americas (2025) described restrictive licensing practices, limited residency positions, accreditation systems that may value training duration over demonstrated competence, fragmented provincial regulations, and residency quotas as barriers to the full integration of ITPs in Canada. Expanded Practice Ready Assessment programs, increased IMG residency opportunities, licensure pathways simplification, and incentives for service in underserved communities were recommended to alleviate the issue.[3]

A December 12, 2025, Research Report published by Internationally Trained Physicians of Canada (ITPC)[4] reported that in 2022, 67% of immigrant ITPs were working in a health-care occupation, with only 28% working as physicians and 13% as clinical or laboratory medicine specialists. The report describes this as a form of "*brain waste*" where highly trained professionals are unable to use their qualifications.

While all the above sounds daunting, new data and new programs (PRA programs for the large part), particularly from over the past 10 years, demonstrates a promising and progressive trend.

With respect of residency programs, IMGs have historically faced a low residency match success rate. In 2019, Schabort and Van Gerven[5] reported that, among 1,725 IMG applicants in the 2019

[2] Maddock M, Goodfellow C, Zohni S, Kouri C. *Part of the Solution: Recommendations for Welcoming Internationally Trained Physicians into Canada's Health Care Sector*. National Newcomer Navigation Network. 2023.

[3] Leiva Tobelem, L. F., Ynoe de Moraes, F., & Caparica Santos, F. N. (2025). Expanding healthcare capacity in Canada: The potential of internationally trained physicians. *The Lancet Regional Health – Americas, 46*, 101095.

[4] Internationally Trained Physicians of Canada (ITPC) (2025, December 12). Research report on internationally trained physicians in Canada

[5] Schabort, I., & Van Gerven, P. (2024). Selection of international medical graduates into postgraduate training positions in Canada. Who applies? Who is selected? *Canadian Medical Education Journal, 15*(2), 49–53.

CaRMS match who submitted rank order lists, only 22.7% matched to a postgraduate training position, and the authors observed that more than 77% did not successfully match. However, since 2019 the landscape for IMGs in the CaRMS match has shifted significantly. The 2026 match rate for current year IMG graduates reached 80.6% in the first iteration. For previous years graduates, the match rate remains lower at 47.8% in the first iteration. Despite more IMGs matching overall, the pool of unmatched applicants remains a significant topic. After the 2026 match iterations, 742 IMGs with prior postgraduate training and 32 current year graduates remained unmatched.

On another positive note, most Canadian provinces now have family medicine PRA pathways (the majority of which were established in the past 10 years), and many are expanding enrolment to increase opportunities for experienced ITPs to enter practice. This represents meaningful progress from earlier periods when access to assessment-based routes was limited and inconsistent across the country. In addition, specialty PRA pathways are now available in three provinces, signalling a gradual but important shift toward broader recognition of demonstrated competence outside traditional residency-based licensure routes.

Pathways to registration in Manitoba:

For our part, Manitoba's pathways include Clinical Assistant registration, various PRA programs, the 1-year Medical Licensure Program for International Medical Graduates (MLPIMG), CaRMS residency routes, and streamlined pathways for some physicians trained in approved or recognized jurisdictions. These pathways are designed to protect the public by ensuring competence, but it is recognized they can also be difficult to understand and navigate, particularly when information, expectations, and decision points are spread across multiple organizations (e.g., Shared Health or SDOs as sponsors, the University of Manitoba as the administrator of training and assessment programs, and CPSM which determines registration eligibility).

For historical context, like most Canadian jurisdictions, Manitoba has relied heavily on Canadian postgraduate training, Royal College certification, CFPC certification, and traditional accreditation pathways as the primary routes to licensure. IMGs and ITPs whose credentials do not fit these established pathways have largely entered practice through:

- CaRMS,
- the MLPIMG, and
- PRA programs.

These pathways reflected a cautious approach to evaluating international credentials, placing significant emphasis on demonstrating equivalency through Canadian assessment or training.

The MLPIMG was established by the University of Manitoba in 2001 as a structured route for internationally trained family physicians to enter Manitoba practice. Overtime, it evolved into a 1-year period of additional training followed by ongoing mentorship and supervision as a provisional registrant while obtaining qualifications for full licensure (certification from the

College of Family Physicians of Canada (CCFP) or a work-place based assessment via the Manitoba Practice Assessment Program (MPAP)).

The development of PRA pathways in Manitoba (which are purely for assessment and not training) represented another significant shift. Rather than requiring a physician to complete further residency training, PRA programs assess whether an experienced physician can practise safely and independently in the Manitoba context:

- The PRA MB-FP (Family Practice, formerly called the IMGACL) was established in 2007 concurrent with several structural changes to the MLPIMG program. Between 2007 and 2022, 107 physicians were successful in this program.
- The PRA MB-SP (Specialty Practice, formerly the NRSAP) was established in 2001 and has evolved since then to include numerous specialty fields of practice. Between 2001 and 2024, 140 specialists were successful in this program.

The following table shows registration data over the past 6 years for individuals entering the MLPIMG, PRA MB-FP, and PRA MB-SP programs:

YEAR	MLPIMG	PRA MB-FP	PRA MB-SP
2020/21	20	1	4
2021/22	20	0	6
2022/23	20	4	8
2023/24	25	0	20
2024/25	30	0	24
2025/26	30	12	6

Of note, the PRA MB-FP had no 2021 intake due to COVID and was suspended from 2023 to 2024 for redesign, with relaunch in 2025. Prior to 2020, the intake was an average of ~8 per year since it was established in 2007.

Physicians who successfully complete the MLPIMG or a PRA program are licensed by CPSM as provisional registrants under supervision until they obtain qualifications for full registration (i.e., certification from the RCPSC, CCFP, SEAP, or MPAP). **It is important to note that formal mentorship is required for those who participate in these programs.** The Mentorship Program is administered by the University of Manitoba's IMG Program. At present, the Mentorship Program is not offered to other ITPs who become licensed in Manitoba, for example via approved or recognized jurisdiction routes to licensure.

A major recent development in Manitoba has been the increasing focus on understanding and recognizing international education and training systems directly. For some jurisdictions, this can result in a direct pathway to full registration. For others, it may represent a pathway to provisional registration with CPSM without the need for further training or a PRA.

Further discussion on CPSM's work regarding jurisdictional recognition and other changes to our registration and licensing framework are discussed below **at Part III**, given these changes happening in parallel with, and were informed by, efforts undertaken by the IMG Working Group.

Workforce data:

National data published by the Canadian Institute for Health Information (CIHI) in February 2024 showed that IMGs account for roughly 27% of Canada's physician workforce, with an even greater presence in family medicine. IMGs represented 31% of family medicine physicians nationally in 2022, compared with 23% of specialists.[6] This reliance is especially important in primary care, rural and remote practice, and communities where physician recruitment and retention are longstanding challenges. **Manitoba's dependence is even more pronounced, with IMGs now representing approximately 37% of all licensed physicians in Manitoba.**

REPORT YEAR	NEW PHYSICIANS WITH INTERNATIONAL MD (IMGS)	SHARE OF NEW REGISTRATIONS	IMG SHARE OF TOTAL INDEPENDENTLY PRACTICING PHYSICIANS
2020/21	98	41.9%	32.0% (987/3,083)
2021/22	94	40.3%	32.6% (1,028/3,157)
2022/23	92	44.0%	32.8% (1,051/3,201)
2023/24	135	47.7%	33.0% (1,100/3,334)
2024/25	165	54.6%	35.0% (1,224/3,498)
2025/26	216	61.0%	37.0% (1,367/3,696)

IMGs play a particularly critical role in maintaining access to care in rural and northern communities in Manitoba. Physician numbers for the North from August 2026 show:

- CMGs in family practice: 29.3%
- **IMGs in family practice: 42.6%**
- CMGs in specialty practice: 15.7%
- **IMGs in speciality practice: 12.4%**

CPSM also registers Clinical Assistants, who are primarily IMGs, and has done so since 2000. They must practice under physician supervision. Many of these registrants apply for various pathways to physician registration while maintaining practice in medicine. The number of registered Clinical Assistants has more than doubled in Manitoba in the past 6 years:

Year	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	2025/2026
CAs	95	101	121	141	176	224

Recruitment of IMGs and ITPs is among the numerous approaches being pursued in Canada and Manitoba to address physician shortages.

[6] https://www.cihi.ca/en/the-state-of-the-health-workforce-in-canada-2024/go-in-depth-2024-health-workforce-data

In terms of need, CIHI data from 2024 indicated that Manitoba had 225 physicians per 100,000 population compared with a Canadian average of 241 per 100,000. It was calculated Manitoba would need to add approximately 246 physicians to meet the national average. This represented a substantial improvement from the estimated shortfall of 445 physicians reported for Manitoba in 2022.

Since May of 2024, the total number of physicians licensed in Manitoba has increased from 3,310 to 3,794 (as of July 31, 2026). This is an increase of 484 physicians or 14.6%, which equates to approximately 253 physicians per 100,000 population. This increase coincides with increased residency positions, changes to registration pathways impacting IMG and ITP eligibility, and recruitment efforts both nationally and internationally.

It should be noted that the increase in physician numbers has significantly ameliorated shortfalls in some but not all geographic regions and fields of practice in Manitoba. For example, there remains significant need in Emergency Medicine, particularly in rural practice settings.

Insights:

The above data signals the effectiveness of the multitude of approaches undertaken to increase physician numbers in recent years and address shortages. In this context, it is now a good time to focus more of our efforts and resources on increasingly pressing issues relating to system integration, adaptability, practice supports for IMGs and ITPs, long-term retention, and support for practice assessors and supervisors – topics which are further discussed in this report.

Review of literature and other publications

This part of the report situates the Working Group's findings within the broader policy, research, and regulatory context. **It shows that the challenges identified by Manitoba IMGs and ITPs are not isolated or new, but reflect longstanding national issues related to registration, assessment, orientation, mentorship, workplace culture, racism, discrimination, and community integration.** This context helps explain why the Working Group moved beyond problem identification toward practical regulatory responses, including the survey analysis, orientation program, Standard of Practice, and recommendations that follow in later parts of the report.

Federal initiatives in the early 2000s:

The need to better support IMGs and ITPs is not new. For more than two decades, national reviews and policy reports have recognized that improving IMG integration requires coordinated action across licensure, assessment, orientation, workforce planning, and support systems.

A **2002 Senate Committee report on 'The Health of Canadians – The Federal Role'**[7] examined the state of Canada's publicly funded health care system at the time and the federal role in reforming it to ensure sustainability. The report included the need for a national strategy to enhance the integration of IMGs. Of particular interest, Chapter 11 at section 11.4 stated:

> *There are some signs of progress, however.* ***In April 2001, Manitoba launched the first permanent program in Canada to assist IMGs to obtain medical licences.*** *It relies on a three-stage Clinicians Assessment and Professional Enhancement (CAPE) process, an evaluation tool developed by the University of Manitoba's faculty of medicine, to assess the medical knowledge and clinical skill of foreign-trained doctors. The CAPE program has proved so successful that the College of Physicians and Surgeons of Nova Scotia refers IMG applicants who do not have licensed North American training or clinical practice experience to the Manitoba program for assessment.*

The CAPE process described in the above excerpt is in reference to the predecessor to the MLPIMG and Manitoba's Practice-Ready Assessment programs for family and specialty practice.

Connected to this work, the Commission on the Future of Health Care in Canada published its final report in November of 2002: **'Building on Values: The Future of Health Care in Canada'**[8] (Romanow Report). Key findings, many of which remain relevant today, include the following:

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[7] Senate, Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role*, Vol. 6: *Recommendations for Reform*, chaired by Michael J.L. Kirby (Ottawa: Senate of Canada, October 2002), https://sencanada.ca/en/content/sen/committee/372/soci/rep/repoct02vol6-e.

[8] Commission on the Future of Health Care in Canada. (2002). *Building on values: The future of health care in Canada* (Cat. No. CP32-85/2002E-IN). Government of Canada. https://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

- IMGs face a lengthy, complex approval and integration process spanning several years. The report highlights that many foreign-trained professionals struggle to find meaningful employment in Canada's health care system as a result.
- The report called on federal/provincial governments and professional associations and licensing bodies to streamline the process for recognizing foreign credentials and evaluating competencies to integrate qualified IMGs faster.
- The report recommended providing bridging programs, additional residency positions, and upgrading pathways to help international graduates meet Canadian standards and licensing requirements.
- While acknowledging the role IMGs play in addressing supply shortages, especially in rural and remote communities, the report cautioned against actively recruiting health workers from developing nations experiencing critical health personnel crises of their own.
- IMGs were identified as a vital component of a broader, coordinated national strategy for Health Human Resources (HHR) planning to balance physician supply and distribution across Canada.

Arising in the context of the above work, the '**Canadian Task Force on Licensure of International Medical Graduates**' - which was a 2004 initiative created to identify and reduce the barriers that IMGs and ITPs face when trying to obtain a medical license and practice in Canada - published a final report in February 2004[9] that set out six recommendations (that are consistent with the Romanov Report):

- expand assessment and training capacity,
- move toward more consistent licensure requirements,
- strengthen supports for IMGs navigating licensure,
- develop orientation for faculty and physicians who work with IMGs,
- improve systems to track and recruit IMGs, and
- establish a national research agenda to evaluate IMG integration strategies.

The Task Force report recognized the ethical dimensions of international recruitment and emphasized the need to support qualified IMGs already living in Canada.

Since these early national reports, work to improve IMG and ITP integration has steadily progressed. That said, many of the same issues identified more than two decades ago remain unresolved or only partially addressed, including limited assessment and training capacity, inconsistent licensure requirements, variable orientation and support programs, gaps in mentorship availability, incomplete workforce data, and the need for stronger evaluation of integration strategies. The persistence of these themes underscores that sustained attention and coordinated action are still required in all areas originally identified.

[9] HC, 2004. *Report of the Canadian Task Force on Licensure of International Medical Graduates*, Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources. Canada. Retrieved from https://coilink.org/20.500.12592/1mk6twn on 17 Aug 2026.

Transitioning into a new practice environment:

The transition experience for physicians entering any new practice environment will be shaped simultaneously by professional, organizational, geographic, and personal factors. Several studies have shown that successful entry into practice very much depends on workplace culture and the receiving practice environment. IMGs and ITPs need supports that address practical integration into local practice environments as well as their professional and broader communities.

Zulla et al. (2008)[10] found that IMGs ranked knowledge of the Canadian health care system, pharmaceutical and hospital formularies, and hospital systems among their highest-rated challenges, and the study's description of macro-level issues included the need to learn institutional rules, procedures, protocols, and systems such as requesting investigations and using software to track patient records.

Understanding communication norms and working relationships were also highlighted by Zulla et al. as transition challenges. The study further noted that IMGs may experience loneliness, social isolation, concerns about family members left behind, diminished social status and self-esteem, limited financial resources, and visa or immigration worries, all of which factors may exacerbate transition challenges. The study concluded that a comprehensive and integrated supports as well as an orientation program are needed to facilitate IMG success in practice.

Lockyer et al. (2011)[11] explored how physicians experience relocation into a new community and practice setting, using qualitative interviews with 20 family physicians, internists, and pediatricians who had recently moved to Calgary. Their study found that transition experiences are shaped by both the professional context - workplace organization, collegiality, administrative and technical support – as well as the geographic context - housing, family adjustment, community integration, and that transition experiences are strongly mediated by internal factors such as adaptability, prior relocation experience, and self-advocacy, as well as external supports, including family, colleagues, mentors, and professional networks.

Lockyer et al. found that physicians who joined well-functioning units with clear roles, orientation, and supportive colleagues experienced smoother transitions, while those without a defined job, professional networks, or resolved licensure issues—particularly those entering community practice—faced greater stress and uncertainty. The authors conclude that structured institutional supports, including mentorship or "*buddy*" systems and longitudinal educational activities, are critical to integrating physicians effectively, reducing transition-related stress, and supporting both professional performance and personal well-being during relocation.

[10] Zulla R, Baerlocher MO, Verma S. International medical graduates (IMGs) needs assessment study: comparison between current IMG trainees and program directors. BMC Medical Education. 2008;8:42.

[11] Lockyer, J., Wycliffe-Jones, K., Raman, M., Sandhu, A., & Fidler, H. (2011). *Moving into medical practice in a new community: The transition experience*. *Journal of Continuing Education in the Health Professions, 31*(3), 151-156.

In their study, **Neiterman and Bourgeault (2015)**[12] described professional integration as a process of professional resocialization in which internationally educated professionals must adapt to a new culture of practice, including local professional roles, responsibilities, communication with patients and team members, and professional relationships, workplace hierarchies, communication patterns, technologies, clinical tests, and "*the Canadian way*" of performing professional tasks. Their analysis emphasizes that transition to practice in Canada is not simply adaptation to a new workplace, but often adaptation to a new culture of practice that combines prior skills with new skills and communication patterns.

Neiterman an Bourgeault note that the transition into practice occurs in a context where internationally educated professionals may experience institutional and interpersonal discrimination, and where local stereotypes and assumptions can shape integration. Their professional resocialization analysis supports the need for structured supports that help internationally educated professionals orient to the new environment while maintaining their professional identity.

Triscott et al. (2016)[13] conducted qualitative interviews and focus groups with 27 participants, including family physicians, allied health professionals, and residents in Alberta regarding the perceived strengths that IMG family medicine residents possess and the challenges they are perceived to encounter in integrating into Canadian family practice. Although focused on family medicine residency, this study provides insights regard training and orientation opportunities that would benefit any physician entering a new practice environment.

Respondents indicated that IMG residents often bring substantial prior clinical experience, specialist training, and advanced qualifications that can enrich training programs. They noted clinical strengths as well as multilingual abilities, cultural insight, and capacity to build trust with diverse and immigrant communities. The authors identified five major areas where IMG residents experience challenges when integrating into Canadian family practice: communication, clinical practice differences, learning culture, professional norms, and personal settlement pressures.

Communication was the most common concern, extending beyond language proficiency to include idioms, accents, tone, humour, non-verbal cues, and Canadian expectations for patient and team communication. Clinical challenges included adapting to common Canadian presentations, preventive and family medicine-focused care, mental health, gender-related care expectations, LGBTQ+ care, medication naming, and diagnostic systems.

Triscott et al. found that some IMGs require time to adjust to Canadian educational and professional norms, including self-directed learning, reflection, open discussion, constructive feedback, team-based care, gender equality, and patient-centred decision-making. These

[12] Neiterman E, Bourgeault IL. *Professional integration as a process of professional resocialization: Internationally educated health professionals in Canada*. Social Science & Medicine. 2015;131:74-81.
[13] Triscott JA, Szafran O, Waugh EH, Torti JMI, Barton M. *Cultural transition of international medical graduate residents into family practice in Canada.* International Journal of Medical Education. 2016;7:132-141.

transitions can be difficult for physicians trained in more hierarchical or physician-directed systems. The authors emphasize that successful integration requires structured medico-cultural education, explicit teaching of Canadian practice norms, communication training, support for feedback and learning transitions, and recognition of the significant personal, financial, immigration, and family pressures IMGs may face.

A 2020 qualitative study by Lagoo et al. examined how physicians experience working in hospitals outside their home institutions and the patient-safety risks created by inadequate onboarding. While not ITP specific, this study is on point. Based on interviews with 20 physicians across multiple specialties, the study found that onboarding is often minimal and focused only on basic logistics, leaving physicians without critical knowledge of local workflows, resources, roles, and emergency procedures, and without strong working relationships with the care team.

Participants in the study consistently identified emergency situations as the most challenging aspect of practicing in an unfamiliar setting. Lack of knowledge about local resources, escalation pathways, transfer processes, translation services, emergency response systems, and institutional capabilities created delays in care and increased perceived risks to patient safety. Several physicians described near misses that resulted primarily from unfamiliarity with local systems rather than deficiencies in clinical expertise.

The authors conclude that structured onboarding, including explicit orientation to institutional differences, mentorship, and intentional relationship-building, is essential to support safe, effective practice when physicians enter new clinical environments and represents a significant, underused opportunity for quality and safety improvement.

In conclusion, the literature has been consistent in identifying that supportive colleagues, clear expectations, practical orientation, constructive feedback, and accessible mentorship as key predictors of success and wellbeing in transitioning into a new practice environment.

Conversely, inadequate orientation, limited understanding of local systems and expectations, poor communication supports, professional isolation, and experiences of discrimination impede the professional integration of physicians. These challenges may affect confidence, workplace relationships, physician well-being, and the ability to function effectively within interprofessional teams, with potential implications for the quality and safety of patient care.

<u>Racism and discrimination:</u>

This section examines racism, discrimination, and cultural insensitivity as practice-environment factors that can directly affect the transition, integration, and retention of IMGs and ITPs.

Racism and cultural insensitivity in healthcare operates at three interconnected levels, all of which can impact ITPs and IMGs in their transition into practice:

1. **Interpersonal racism:** prejudicial attitudes, stereotyping, dismissive communication, differential treatment, and discriminatory behaviours.

2. **Institutional or organizational racism:** policies, practices, and structures that create inequitable experiences or outcomes.
3. **Structural racism**: broader historical and societal forces, including colonialism, that shape health systems and health outcomes.

These factors are broadly known to affect both patients and healthcare providers.

On an interpersonal level, reported experiences include discriminatory comments, exclusion from advancement opportunities, tokenism, microaggressions, greater scrutiny of performance, and lower psychological safety.

A 2023 Manitoba racial climate survey[14] of healthcare professionals that was developed by the Shared Health Racial Climate Survey Working Group found that 56% of Indigenous, Black, and racialized respondents reported experiencing racism in the previous year. Such experiences contribute to burnout, moral distress, workforce attrition, and reduced retention in underserved areas. The survey was conducted across Manitoba's health system, with 6,677 respondents, representing approximately a 13% response rate. Most respondents were clinical professionals. Physicians, and specifically, IMGs or ITPs, were not reported separately. Per the survey:

- Common experiences included:
    - Microaggressions.
    - Being patronized or treated negatively because of race.
    - Having ideas dismissed or ignored.
    - Greater scrutiny than colleagues.
    - Lack of recognition for accomplishments.
    - Patients refusing care because of the provider's race.
- Respondents reported experiencing or observing racism from:
    - Patients and families (52%).
    - Co-workers (43%).
    - Leaders/managers (15%).
- Respondents indicated that reporting systems are poorly understood and not well trusted, with 49% of respondents indicating they did not know how to report racism. Among those who experienced or observed racism, 65% of Indigenous, Black, or Racialized respondents never reported it. Common reasons for not reporting included:
    - Belief that nothing would be done.
    - Lack of knowledge about reporting processes.
    - Concerns about confidentiality.
    - Fear of reprisal.

  Only 38% felt they were taken seriously when reporting incidents, and only 24% said action was taken.
- Participants strongly supported mandatory and ongoing education on:
    - Racism and microaggressions.
    - Cultural safety.

[14] https://sharedhealthmb.ca/about/racism-disrupted/racial-climate-survey/

    - Bias and stereotypes.
    - Anti-racism.
    - Truth and Reconciliation.

Another significant report reviewed by the IMG working Group was a joint report of racism from the Saskatchewan Medical Association (SMA) and the College of Physicians and Surgeons of Saskatchewan (CPSS). This report was based on survey results from the fall of 2023. There were 462 responses from physicians, residents, and medical students (13% response rate). The SMA/CPSS Racism Report found that nearly half of physician respondents in Saskatchewan experienced racism; visible-minority physicians, many of whom are IMGs, are disproportionately affected, with impacts on mental health, career progression and leadership opportunities. They recommend anti-racism training, fair hiring and promotion, and specifically calls for better appreciation of skills of colleagues trained outside Canada. The results:

- The most identified sources of racist behaviour were:
    - Patients (62%).
    - Patient family members (39%).
    - Physician colleagues (39%).
    - Nurses (31%).
    - Physician leadership (29%).
    - Administrative leadership (26%).
- Among those who experienced racism 87% reported emotional impacts and 40% reported physical impacts. Respondents described demoralization, stress, reduced wellbeing, and in some cases consideration of leaving the province.
- Among respondents who experienced racism only 14% formally reported the incident. 73% of those who reported were dissatisfied with the outcome. The most common reasons for not reporting included:
    - Belief that leadership would not act.
    - Fear of being viewed as a complainer.
    - Fear of repercussions.
    - Lack of confidence in reporting systems.

- The problem extended beyond personal experiences:
    - 68% had witnessed or been made aware of racism toward others.
    - 75% said racism is observed sometimes or always.
    - 80% of witnesses did not formally report incidents.
    - 83% reported emotional impacts from witnessing racism.
- Respondents specifically raised concerns that IMG licensing and registration processes may be perceived as discriminatory or biased. The report notes a perception that physicians trained outside Canada are not always fully valued or understood. Respondents recommended greater recognition of ITPs' skills and experience.
- The report recommended:
    - Strengthen anti-racism education and awareness efforts.

- Improve cultural competency and implicit bias training.
- Create safe, trusted reporting mechanisms.
- Improve investigation and response processes.
- Review hiring, promotion, and leadership practices.
- Increase diversity in leadership and governance.
- Review IMG licensure and membership processes for potential bias.
- Provide stronger support and mentorship for physicians experiencing racism.
- Work collaboratively with healthcare organizations, regulators, educators, and the public.

Shared Health is pursuing a strategic plan withing its network to meaningfully address the issues identified.

The literature reviewed as well as prior survey data indicates that racism, discrimination, and cultural insensitivity in practice settings are not isolated interpersonal concerns, but systemic factors that affect physician integration, psychological safety, retention, and the quality of practice environments. Racialized healthcare professionals and physicians report frequent experiences of racism, including microaggressions, differential treatment, greater scrutiny, dismissal of contributions, and discriminatory conduct from patients, families, colleagues, and leaders. Survey responses strongly indicate a lack of trust in the reporting mechanism.

Broader community factors:

Broader community support and integration cannot be ignored when considering how IMGs and ITPs successfully enter and remain in practice. While regulatory orientation, workplace onboarding, and professional mentorship are essential, physicians and their families are also adapting to a new community, social environment, and support network. Their ability to establish a sense of belonging outside the clinical setting can directly affect wellbeing, confidence, retention, and long-term success in Manitoba.

The 2011 study Moving into Medical Practice in a New Community[15] found that transition experiences were strongly mediated by external supports, including family, friends, colleagues, mentors, and professional networks. The study concluded that these factors are critical during the adjustment period and that successful transitions require attention not only to workplace onboarding but also to the personal relocation experience. The study notes challenges connected to housing, schools, recreation, spousal adjustment, and establishing social networks. Physicians who were simultaneously managing personal and professional integration often took longer to become established.

[15] Jocelyn, L, et a. Moving Into Medical Practice in a New Community: The Transition Experience.

Focus groups organized by the IMG Working Group

Two focus group sessions were held in April of 2024. Focus group participants were IMGs and ITPs currently practicing in Manitoba. Both sessions had six participants. The first session was held on April 15, 2024, and was moderated by Dr. Nader Shenouda, CPSM President, Chair of the IMG Working Group, and himself an ITP. The second was held on April 25, 2024, and was moderated by Dr. Anna Ziomek, Registrar of CPSM and an ITP. CPSM staff in attendance included Mr. Jeremy de Jong, Registration Director, and Ms. Wendy Elias-Gagnon, Communications Director.

Focus groups were moderated using a discussion guide consisting of five primary questions exploring: (1) challenges encountered in becoming licensed and entering practice in Manitoba; (2) difficulties experienced in the practice environment; (3) supports that were most helpful; (4) supports that were lacking or would have been beneficial; and (5) suggested changes to better prepare and support IMGs and ITPS entering practice. Additional closing questions invited participants to identify priority issues and share any other relevant experiences. Discussions were documented by CPSM staff, and the notes were thematically analyzed to identify recurring barriers, supports, and recommendations for change.

Focus group participants described number significant obstacles at multiple levels. They described a lack of appropriate orientation and onboarding, a lack of training, especially minimal on-site hands-on exposure, or rotations misaligned with real needs (e.g., all outpatient experience when inpatient exposure was needed). They also pointed to unclear system navigation, including not knowing where to go for help and insufficient communication. Participants expressed a desire for better mentorship, more coordinated system supports, orientation and practical guidance, and educational resources.

A supportive practice environment, supportive colleagues, clear expectations, constructive feedback, and accessible mentorship were repeatedly identified as protective factors by focus group participants. Where these supports were present, physicians described smoother transitions and greater confidence. Where they were absent, physicians described isolation, uncertainty, unclear expectations, and difficulty knowing where to seek help.

Focus-group feedback indicated that successful recruitment, integration, and retention of IMGs and ITPs depend not only on professional supports but also on the successful settlement and integration of their families. Focus group participants repeatedly referenced family as a major driver in choosing Manitoba. Family stability, spousal employment, community belonging, access to settlement resources, and opportunities for social connection were identified as highly important protective factors.

The focus groups were especially important because they grounded the Working Group's work in direct physician experience. This helped shape the content of the Working Group's survey of registrants, including identification of themes and problem areas that the broader membership survey should address.

Part II – IMG Survey (2025) Qualitative and Quantitative Analysis (Dr. A. Man)

Part II of this report was prepared for CPSM by Dr. Ada Man, MD, FRCPC.

The survey

The Working Group's survey, entitled "Practice Environment and Integration Experience Survey for International Medical Graduates or Internationally Trained Physicians," was designed to compare the experiences of IMGs, ITPs, and Canadian-trained physicians entering and establishing practice in Manitoba. This was to complement the literature review and focus groups by testing whether the issues identified through those sources were reflected more broadly among registrants.

The survey explored registration and assessment pathways, orientation needs, clinical and community integration, understanding of CPSM and self-regulation, workplace culture, discrimination and harassment, reporting behaviours, mentorship, supports, satisfaction, and retention. These topics were selected because they reflect the main dimensions of transition to practice; formal licensure requirements, practical system navigation, professional expectations, workplace environment, and longer-term decisions about remaining in Manitoba.

The survey helped test whether the issues raised in the focus groups were broader in scope and provided quantitative and qualitative information to inform the Working Group's recommendations.

The survey was open from September 17, 2025, to October 17, 2025.

Methods

The survey was sent to all medical graduates in Manitoba via email. The email emphasized the anonymous nature of the survey results and that all physicians, including those of IMG and non-IMG background, were invited to participate.

Quantitative survey data were analyzed using descriptive statistics and comparative tests between IMG and non-IMG respondents. Continuous variables were assessed using independent samples t-tests with Welch's correction where variances were unequal. Categorical variables were examined using Pearson chi-square tests or Fisher's exact tests as appropriate. Results were summarized using frequency distributions, proportions, and mean scores, supplemented by graphical visualization.

Qualitative free-text responses underwent thematic analysis. Responses were imported into NVivo, coded line-by-line, and organized into hierarchical code structures. Codes were iteratively refined and aggregated into thematic categories representing recurrent patterns across respondents. Themes were synthesized to identify shared and divergent experiences between IMG and non-IMG respondents.

Summary of survey analysis

This section provides a high-level summary of the survey analysis. A comprehensive, question-by-question analysis is presented in the sections that follow. To streamline the reporting of survey findings, both IMGs and ITPs are referred to as IMGs throughout this report.

Demographics

The survey was sent to 4011 registrants and there were 299 respondents (7.45% response rate), 190 were IMG, and 109 were non-IMG. Median age group was 40-49, with equal gender distribution in each group.

Orientation

All orientation topics were rated highly by respondents, IMGs more so than non-IMGs. IMGs especially want information on Manitoba's healthcare system navigation, pathway to licensure, orientation specific to practice location, safe prescribing practices, office practice operations and billing, and information about resources (e.g., benefits) for physicians.

Challenges, Professional expectations, Supports and Factors crucial to success when entering a new practice environment.

Major clinical challenges identified by IMGs revolved around health system navigation processes: specialist referrals, process for patient transfers, and billing. Socially, IMGs noted difficulty with social expectations and unwritten rules, as well as lack of opportunities to get to know colleagues and lack of peer support. Both groups had some challenges understanding CPSM's complaint process and its role in quality improvement.

In addition to these clinical, social, and regulatory challenges, new registrants also encountered inconsistent adherence to CPSM's professional expectations**.** IMGs and non-IMGs felt that established registrants were not always providing clear guidelines and constructive feedback nor consistently fostering mentorship and leadership opportunities. At the same time, they also emphasized that registrants were not receiving feedback in a positive way.

With respect to support that could improve the transition experience in light of these challenges, registrants described considerable inconsistencies in what was available to them. While the majority had access to a mentor and received facilitated introductions, most did not have formal onboarding (only 52% of IMGs), nor support related to practice setting policies and community groups. On the other hand, respondents noted that informal support from colleagues, mentors, other IMGs, and the community were vital to their success. Suggestions for additional supports and resources for new registrants focused on health system navigation, social connections, and supports for life outside medicine.

Finally, in terms of factors and behaviours crucial to success during this transition period, respondents offered suggestions focused on positive individual attributes, strengthening system-

level support, and mitigation of systemic barriers. Helpful attributes for both new and established registrants include openness, adaptability, and respectfulness. IMGs emphasized that the system needs to ensure consistent quality of IMG supervisors and mentors, while non-IMGs brought attention to ensuring IMGs are oriented to Canadian EDI principles and practice norms. All respondents recognized the need to break down systemic barriers of power imbalances, discrimination, and inequities.

Regarding consistency in quality of IMG supervision and mentorship, the survey revealed that registrants who were receiving new IMG registrants into their practice were only somewhat informed about them (mean 2.63/5 rating), pointing to a gap in supervisor/mentor preparation.

Discrimination and harassment experiences

Concerningly, the majority (64.5%) of respondents reported having experienced some form of discrimination and/or harassment. This was most commonly from other physician colleagues, followed by patients/family, leadership, and non-physician colleagues. IMG respondents did not report more discrimination experiences than non-IMGs, but did report "*Yes, prefer not to say*" more often, perhaps suggesting a fear of reporting.

Across both groups, being ignored after expressing opinions and ideas and discrimination based on personal attributes were most frequently cited. IMG respondents more frequently noted that their education and skills were not recognized equally to their colleagues.

A little over half of the respondents who experienced discrimination or harassment (51.8%) sometimes or always reported these incidents. The most frequently cited reason behind not reporting was a worry about negative consequences for IMGs, and the belief that nothing would be done about it, for non-IMGs.

Priorities noted by IMG respondents to help prevent or respond to these experiences included a trusted, nonbiased and accountable reporting pathway, enforced policies against discriminatory behavior, and education/awareness building about IMG capabilities to build trust among the public and peers. Both groups pointed to the importance of leadership and systems accountability, peer support mechanisms, as well as ensuring all registrants receive appropriate and ongoing training to ensure EDI principles are upheld.

Related to the topic of discrimination, the majority of IMG respondents felt that they were being held to a different standard by the system, patients, and colleagues, while the majority of non-IMGs did not think so.

Reasons for coming to and staying or leaving Manitoba

Most IMG respondents came to Manitoba specifically to practice medicine, while fewer non-IMGs did so. The most important reasons for both groups staying in the province were personal reasons including being settled with family and engaged with the community as well as a sense of commitment for delivering care to a particular community (in particular for IMGs). Career and

professional reasons as well as location and lifestyle were cited but with less frequency and emphasis.

17.1% of respondents were considering leaving Manitoba within the next five years. The most cited reasons included poor work environments including interpersonal issues and under-resourced settings, burnout, dissatisfaction with leadership.

Insights from Additional Narrative Responses (majority from IMG respondents)

Challenges encountered by IMG registrants can be divided into key areas:

1. Transition period distress early after arrival to Manitoba (isolation, stress, financial strain).
2. Gaps in integration support, including inconsistencies in mentorship and peer networks.
3. Professional and social isolation during return of service rural placements.
4. Mismatch between training and work settings (resource poor, high demand).
5. Perceived inequities across all aspects of integration including interpersonal, institutional and systemic.

Key protective factors that lead to IMG success include being valued, trusted, needed, appreciated; experiencing a sense of belonging; commitment and desire to reciprocate within a welcoming community and work team.

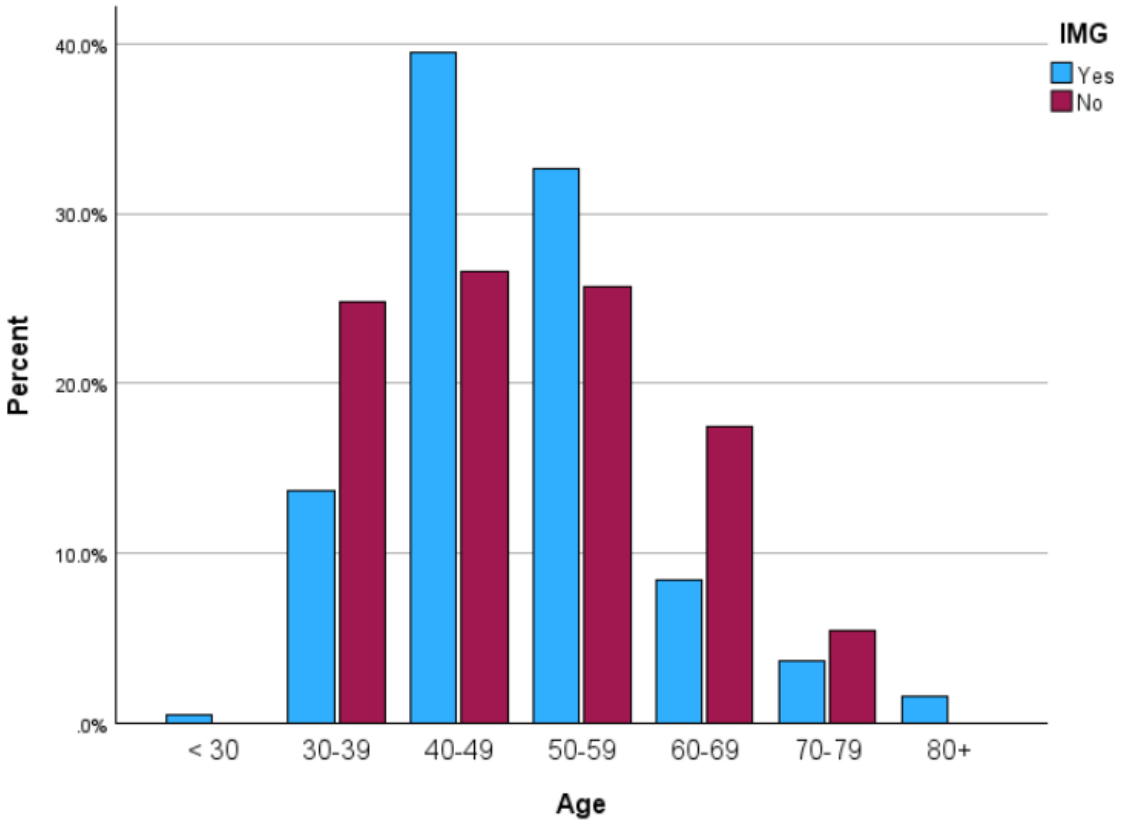
Conclusion

Taken together, these findings highlight that while IMGs bring essential skills and valuable commitment to Manitoba's health system, their early practice experiences are shaped by significant gaps in orientation, mentorship, workplace culture, and system-level supports. Respondents described challenges across clinical, social, and regulatory domains, including inconsistent onboarding, variable mentorship, unclear expectations, and pervasive experiences of discrimination and inequity. At the same time, they emphasized the protective value of belonging, trust, and supportive communities, as well as the importance of recognizing IMG capabilities and ensuring fair and respectful treatment. These insights underscore the need for coordinated, system-level action to strengthen orientation, enhance supervision and mentorship, promote equity, and improve working conditions. The recommendations that follow **(Part IV)** aim to address these gaps and support safe, sustainable, and successful integration for all new registrants, particularly IMGs.

Demographics:

There were 299 respondents, 190 were IMG and 109 were non-IMG. Median age group was 40-49. Age distribution was more even in non-IMGs whereas it was skewed towards the age group of 40-59, with less respondents >60 years old in the IMG cohort. 45.2% were female and there were no substantial differences in gender distribution between the two cohorts.

	Frequency	Percent
IMG	190	63.5
non-IMG	109	36.5
Total	299	100.0



Gender				
	Frequency	Percent	IMG	Non-IMG
missing	3	1.0%		
F	135	45.2%	44.7%	45.9%
M	161	53.8%	53.7%	54.1%
Total	299	100.0%		

Orientation Topics:

- *4."On a scale from 1 to 5 (1 signifies not important at all and 5 signifies highly important), please indicate how important you believe orientation is to the following topics when entering practice in Manitoba."*

Rating of Orientation Topics for All Participants	Mean
Orientation to your specific practice location and environment.	4.57
Safe prescribing practices in Manitoba.	4.50
Manitoba's healthcare system (regional health authorities, Shared Health).	4.48
Interprofessional communication and teamwork.	4.47
Patient-centered communication and effective communication skills for working with patients.	4.42
CPSM's regulatory role and requirements, including Standards of Practice, Practice Directions, and the Code of Ethics.	4.38
Cultural sensitivity in providing care.	4.35
Practice and remuneration models in Manitoba (e.g. FFS, ROS contract, clinic ownership, etc.) and supports for each (e.g. billing, contract negotiation and interpretation obligations, insurance, etc.).	4.34
CPSM's expectations for continuing professional development.	4.31
Resources and services for physicians in Manitoba (e.g., benefits, CPD, quality improvement, practice advice, mentorship, etc.).	4.29
Commitment to reconciliation with Indigenous peoples.	4.20
Trauma-informed practices in care.	4.14
Physician health and well-being supports (including CPSM's Physician Health Program and services through Doctors Manitoba).	4.08

Survey responses show that most orientation topics were felt to be important to all respondents, with mean ranking of 4.08-4.57 for all topics. The highest-rated orientation topics emphasize the importance of understanding **the local practice setting, safe prescribing practices in Manitoba,** and the **broader healthcare system,** as well as developing strong **patient-centered and interprofessional communication skills.**

Comparing IMG to non-IMG respondents, IMGs tended to rate all topics slightly higher than non-IMGs, whereas non-IMGs varied more in their responses depending on the topic. **IMGs placed significantly greater importance on system-level and regulatory topics**, including Manitoba's healthcare system, remuneration and practice models, CPSM expectations, and available physician supports. They also rated trauma-informed care and commitments to reconciliation highly. Both groups rated communication skills, cultural sensitivity, interprofessional teamwork, safe prescribing, and practice-site orientation similarly, with no significant differences.

Reviewing the highest rated topics in each group, again, understanding about the local practice setting and safe prescribing practices are emphasized for both, however**, IMGs uniquely place**

high value on the practical aspects of practice including remuneration models, and how to navigate resources and supports.

Comparison between IMG and non-IMG respondents for rating of Orientation Topics			
	Mean		Sig*
	IMG	non-IMG	
Manitoba's healthcare system (regional health authorities, Shared Health).	4.59	4.28	**0.004**
Patient-centered communication and effective communication skills for working with patients.	4.37	4.51	0.233
Cultural sensitivity in providing care.	4.40	4.25	0.261
Trauma-informed practices in care.	4.30	3.88	**0.003**
Commitment to reconciliation with Indigenous peoples.	4.32	3.98	**0.013**
Interprofessional communication and teamwork.	4.47	4.46	0.924
Safe prescribing practices in Manitoba.	4.52	4.45	0.504
Practice and remuneration models in Manitoba (e.g. FFS, ROS contract, clinic ownership, etc.) and supports for each (e.g. billing, contract negotiation and interpretation obligations, insurance, etc.).	4.51	4.04	**<0.001**
CPSM's expectations for continuing professional development.	4.48	4.01	**<0.001**
Physician health and well-being supports (including CPSM's Physician Health Program and services through Doctors Manitoba).	4.28	3.74	**<0.001**
Resources and services for physicians in Manitoba (e.g., benefits, CPD, quality improvement, practice advice, mentorship, etc.).	4.51	3.91	**<0.001**
Orientation to your specific practice location and environment.	4.56	4.58	0.885
CPSM's regulatory role and requirements, including Standards of Practice, Practice Directions, and the Code of Ethics.	4.50	4.19	**0.004**

**Independent samples t-test; Welch's adjusted degrees of freedom used due to unequal variances where applicable*

IMG – Top 5 Ranked Orientation Topics

	Mean
Manitoba's healthcare system (regional health authorities, Shared Health).	4.59
Orientation to your specific practice location and environment.	4.56
Safe prescribing practices in Manitoba.	4.52
Practice and remuneration models in Manitoba (e.g. FFS, ROS contract, clinic ownership, etc.) and supports for each (e.g. billing, contract negotiation and interpretation obligations, insurance, etc.).	4.51
Resources and services for physicians in Manitoba (e.g., benefits, CPD, quality improvement, practice advice, mentorship, etc.).	4.51

Non-IMG – Top 5 Ranked Orientation Topics

	Mean
Orientation to your specific practice location and environment.	4.58
Patient-centered communication and effective communication skills for working with patients.	4.51
Interprofessional communication and teamwork.	4.46
Safe prescribing practices in Manitoba.	4.45
Manitoba's healthcare system (regional health authorities, Shared Health).	4.28

Bolded=unique to IMGs

- *5."Are there any other topics you believe should be covered in orientation when entering the Manitoba practice environment that are not listed in the previous question? (free text response)*

For **IMGs**, the free text responses reflected the highest interest in topics related to **Health System Navigation, Licensure, Practice Operations**, and **Equity**, detailed in the table below. **Referral processes to specialists** and the **need for a clearly outlined pathway to licensure** were mentioned frequently by IMGs. Legal and Professional Responsibilities, and Clinical Care topics were cited occasionally.

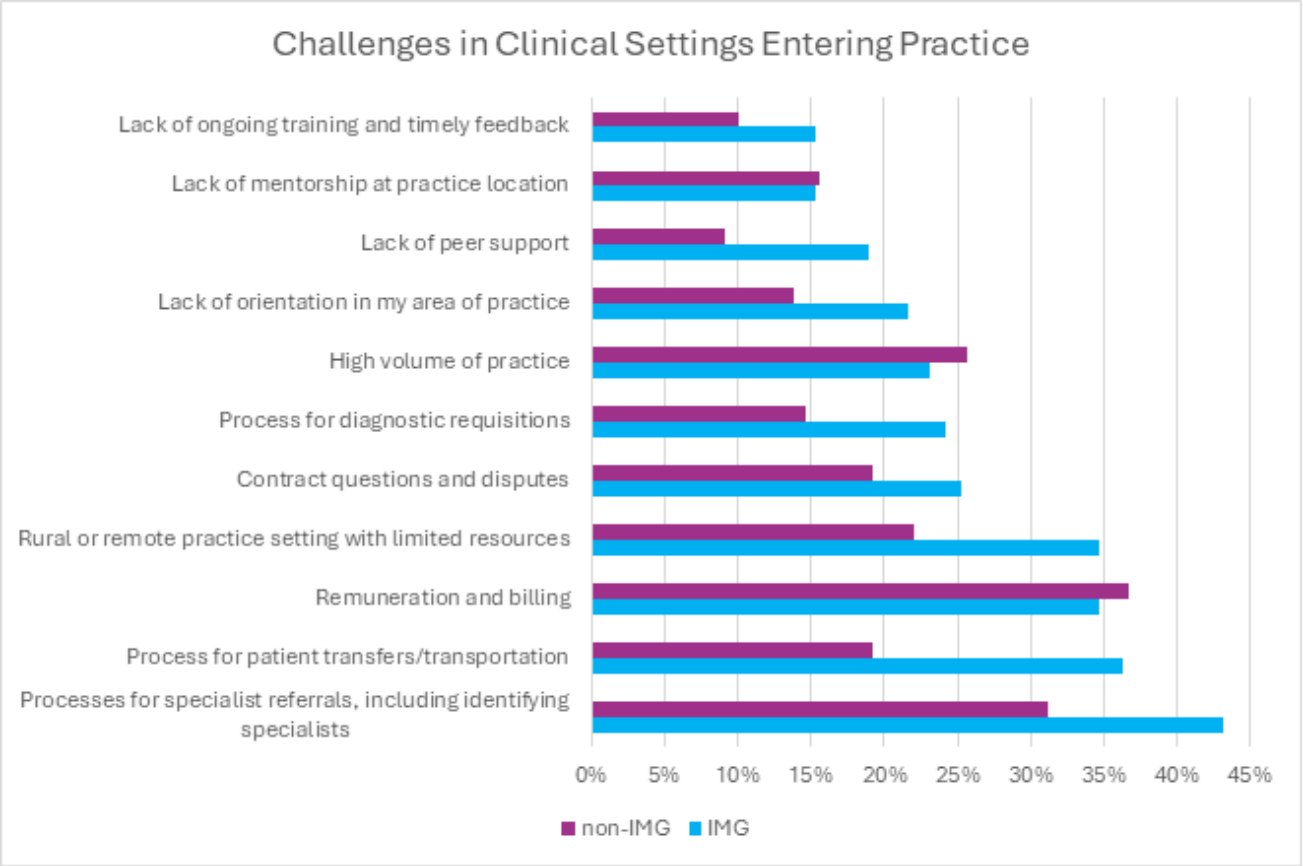
IMG

Many **non-IMGs** approached this question from the perspective of what they believed an IMG would benefit from learning about when entering practice. Their responses emphasized the importance of understanding standards, norms, and appropriate practice, suggesting a focus on **supporting alignment with expected professional and system expectations.** They also gave suggestions about resources not mentioned by non-IMGs (e.g. RACE), possibly reflecting greater familiarity for certain resources in established registrants. **Health System Navigation** and **Standards of Care** were the most frequently mentioned topics, with Equity, Legal Responsibilities, Clinical Care Topics and Supports being reported with lower frequency.

Non-IMG

Challenges when Entering Practice:

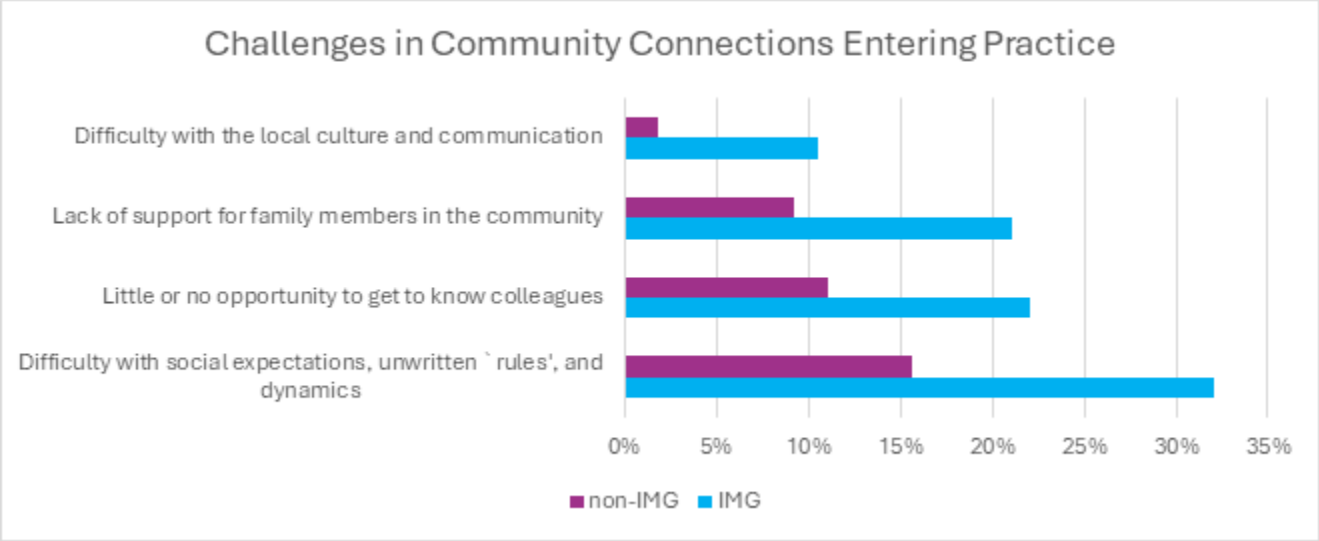
- *6. "When you started practicing medicine in Manitoba, in which areas did you experience significant challenges? Select all that apply regarding clinical practice settings."*



Most frequently cited area associated with significant challenges when entering practice for all respondents was the **Process for specialist referrals.** For IMG respondents, this was also the top concern, along with **Process for patient transfers, Remuneration and billing and Rural/remote practice with limited resources.** For non-IMGs, the most frequently identified challenges were similar, with the exception of less noted challenges for Process for patient transfers (19% vs 36%), likely reflective of differing practice settings. **High volume of practice** was also noted to be a major challenge for non-IMGs.

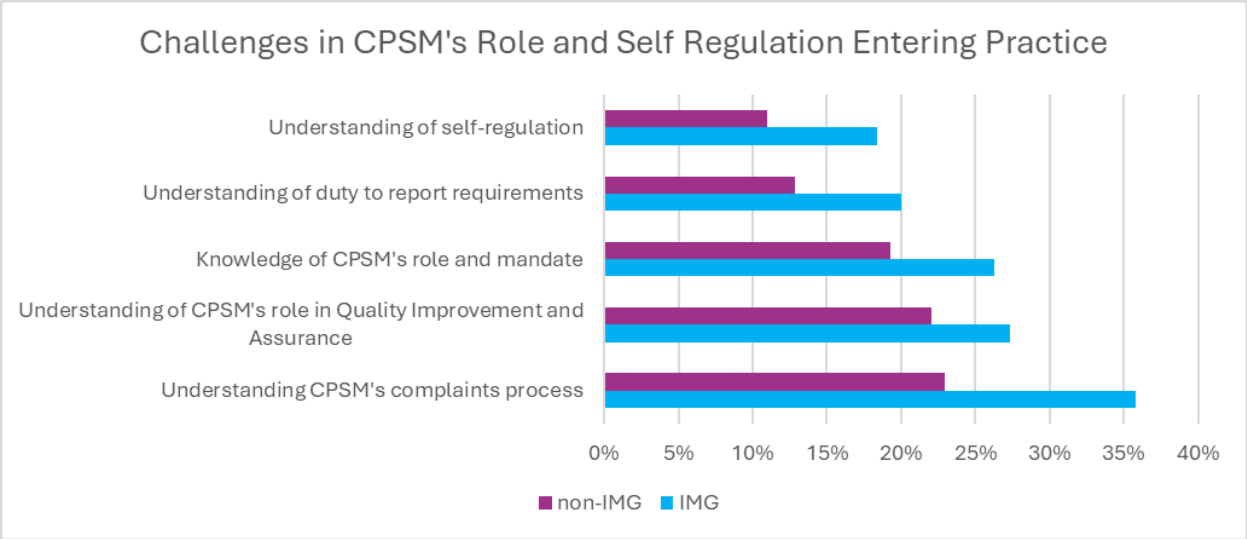
Notably, 19% of IMG respondents noted **Lack of peer support** as a significant challenge vs only 9% of non-IMG respondents.

- *7. "When you started practicing medicine in Manitoba, in which areas did you experience significant challenges? Select all that apply regarding Creating connections in a new community."*



A large proportion of IMG (41.6%) and non-IMG (69.7%) respondents noted that **none of these challenges** applied to them, indicating that in particular for non-IMGs, creating community connections was not a major concern when entering practice. For IMG respondents, the most frequently cited challenge was **Difficulty with social expectations, unwritten rules and dynamics**, followed by **Little or no opportunities to get to know colleagues**. The trend was similar for non-IMG respondents, but still only **16%** and **11%** cited these as challenges, respectively.

- *8. "When you started practicing medicine in Manitoba, in which areas did you experience significant challenges? Select all that apply regarding CPSM's role and self-regulation."*



Challenges in **Understanding CPSM's complaints process** was noted most frequently across all respondents (31.1%) and was also the most frequently selected in each of IMG and non-IMG groups. Overall, IMGs selected each of these areas as challenging more often than non-IMGs, but these **do not seem to be major concerns for either group** ("None of the above apply" was selected by 60.6% non-IMG and 46.3% of IMG respondents). IMGs reported in total more challenges than non-IMG respondents.

Professional Expectations when Entering Practice:

- *9."The goal of this question is to take the current pulse of the practice culture in Manitoba. Specific to the experience of new registrants entering practice in Manitoba, please indicate on a scale from 1 to 5 (1 signifies not being met at all and 5 signifies always met) whether you believe the following professional expectations from CPSM's Code of Ethics and Professionalism are being met by both new and existing registrants of CPSM during the transition period (i.e., first 6 -12 months)"*

Rating of CPSM Codes Being Met Sorted from Lowest to Highest for All Survey Respondents				
	Means			
	All	IMG	non-IMG	Sig*
Registrants are providing clear guidelines and constructive feedback.	3.37	3.51	3.09	0.001
Registrants are receiving feedback in a positive way.	3.42	3.58	3.10	<0.001
Registrants are fostering mentorship and leadership opportunities at the training, practice, and the health system levels.	3.46	3.59	3.23	0.004
Registrants are promoting a culture of training and practice that effectively supports colleagues in need and encourages them to seek assistance.	3.56	3.65	3.38	0.029
Registrants are assigning a reasonable amount of work, particularly during the transition period.	3.63	3.83	3.20	<0.001
Registrants (both new and existing) are building collaborative and respectful relationships.	3.65	3.76	3.45	0.011
Registrants are fostering curiosity and supporting personal and professional development and insight.	3.67	3.81	3.39	0.002
Registrants are communicating clearly and limiting use of jargon/technical terms.	3.69	3.91	3.22	<0.001
Registrants are ensuring cultural sensitivity and inclusiveness.	3.69	3.88	3.31	<0.001
Registrants are showing openness to new knowledge, technologies, ways of practicing, and learning from others.	3.78	3.94	3.45	<0.001

**Independent samples t-test; Welch's adjusted degrees of freedom used due to unequal variances where applicable*

The mean rating relating to all CPSM Codes of Ethics and Professionalism, was 3.59 out of 5, implying that on average, respondents **felt that these expectations were not always being met. Providing clear guidelines and constructive feedback**, **Receiving feedback in a positive way**, and **Fostering mentorship and leadership opportunities** were rated lowest of all the topics (**3.37-3.46**).

Comparing the responses from IMGs to non-IMGs, non-IMGs gave lower ratings overall and these differences were significant. It is uncertain whether respondents interpreted this question as reflecting their observations of how IMGs are treated or to their personal experiences as new registrants, making comparisons of responses between the two groups difficult to interpret.

Factors Crucial to Success When Entering a New Practice Environment:

- *10. Are there other attitudes or behaviours not mentioned on this list that you believe are crucial to success in entering a new practice environment? (free text response)*

Feedback from IMGs highlighted three overarching domains of what they believe to be crucial to success when entering a new practice environment.

1. **Individual Attributes** Key themes included **respectfulness, kindness, humility, openness, adaptability, and a commitment to lifelong learning**. These qualities were seen as essential for both new and current registrants.

2. **System-Level Supports** Respondents identified structural and organizational factors that support IMG integration. These include **better orientation and training for IMG mentors and supervisors**, as well as **consistency in the standards of supervision and mentorship**. Respondents also noted the importance of creating **safe, supportive environments and ensuring that professional expectations including respectful workplace behaviors are reinforced** at the institutional level.

3. **Systemic Barriers** Beyond individual and system factors, respondents described broader challenges that impede IMG success. These included experiences of **discrimination, power imbalances, and defensive silence**. A recurring theme was the **need for the system to more fully recognize and value the skills, experience, and contributions** that IMGs bring to Manitoba's healthcare workforce.

Similarly, three domains overarching domains were identified in the feedback from non-IMG respondents. Some respondents referred to all new registrants while others focused on new IMG registrants when answering this question.

1. **Individual Attributes** Respondents emphasized the importance of strong **professional values** among new registrants, including **collaboration, teamwork, independent problem-solving, and a focus on quality of care over volume.** They also noted the importance of **avoiding unnecessary investigations or referrals** and maintaining respectful interactions across all roles and specialties.

2. **System-Level Supports** Respondents identified several organizational factors that support the success of new registrants. These include **safe and supportive work environments, consistent mentorship, improved communication tools among physicians, and reduced administrative burden**. Respondents also highlighted the importance of **orienting IMGs to Canadian EDI principles** and ensuring **supervisors and senior faculty actively model supportive behaviors**.

3. **<u>Systemic Barriers</u>** Respondents acknowledged broader issues that negatively affect the experiences of new registrants. These included **power imbalances, discrimination, and microaggressions** within the clinical environment.

Both groups are aligned in terms of their beliefs about individual and system level attributes that determine success. There is strong agreement with regards to **professionalism, safe workplace environments**, as well as systemic barriers including **power imbalances** and **discrimination**. IMGs place more emphasis on **ensuring supervisors and mentors who work with IMGs are well trained and informed**, while non-IMGs point out the importance of appropriately **orienting IMGs to Canadian EDI principles** and **clinical practice norms**.

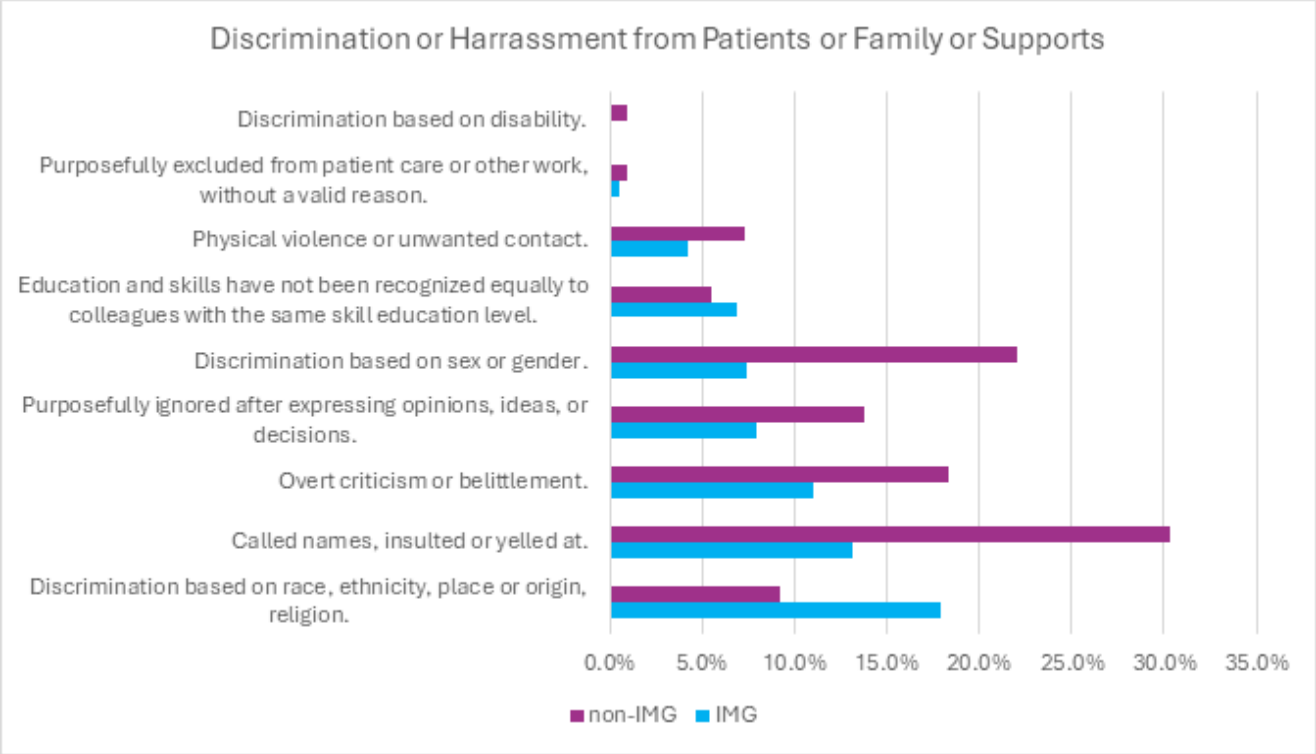
<u>Discrimination and Harassment Experiences:</u>

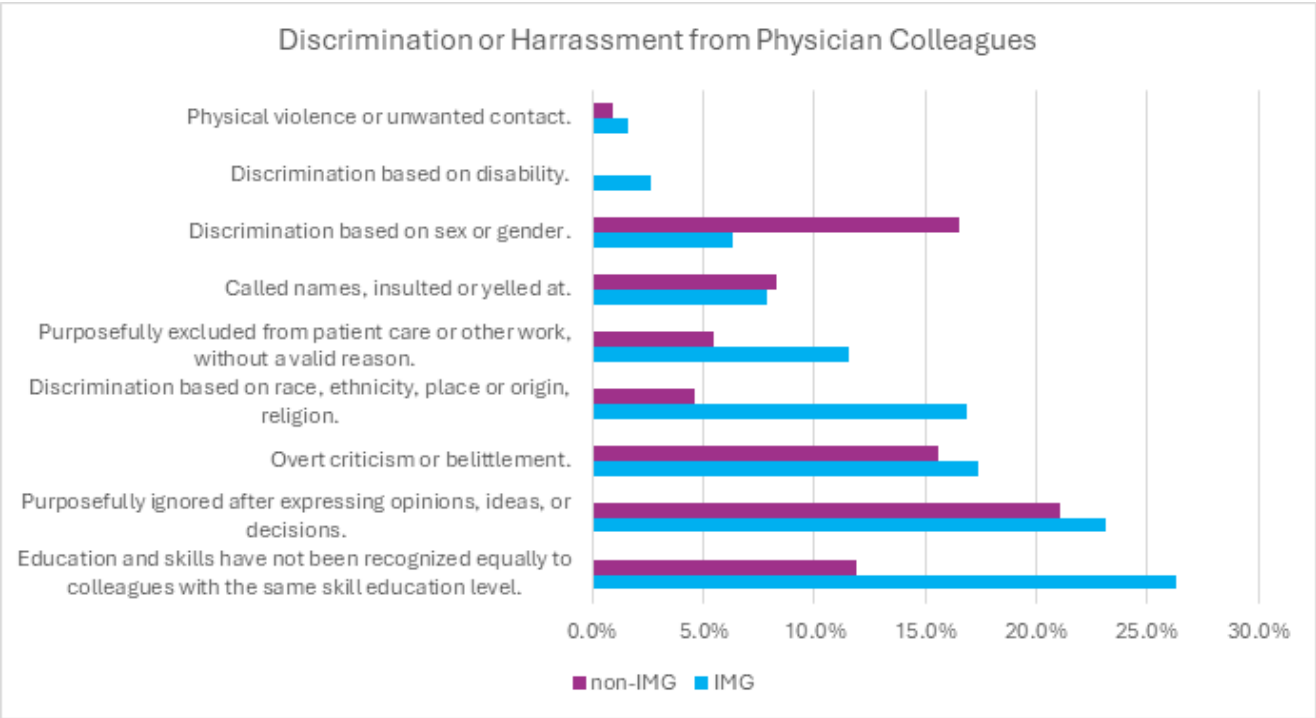
- *11. "In the first year you entered practice in Manitoba, did you directly experience the following in your practice setting, and by who? Check all that apply."*

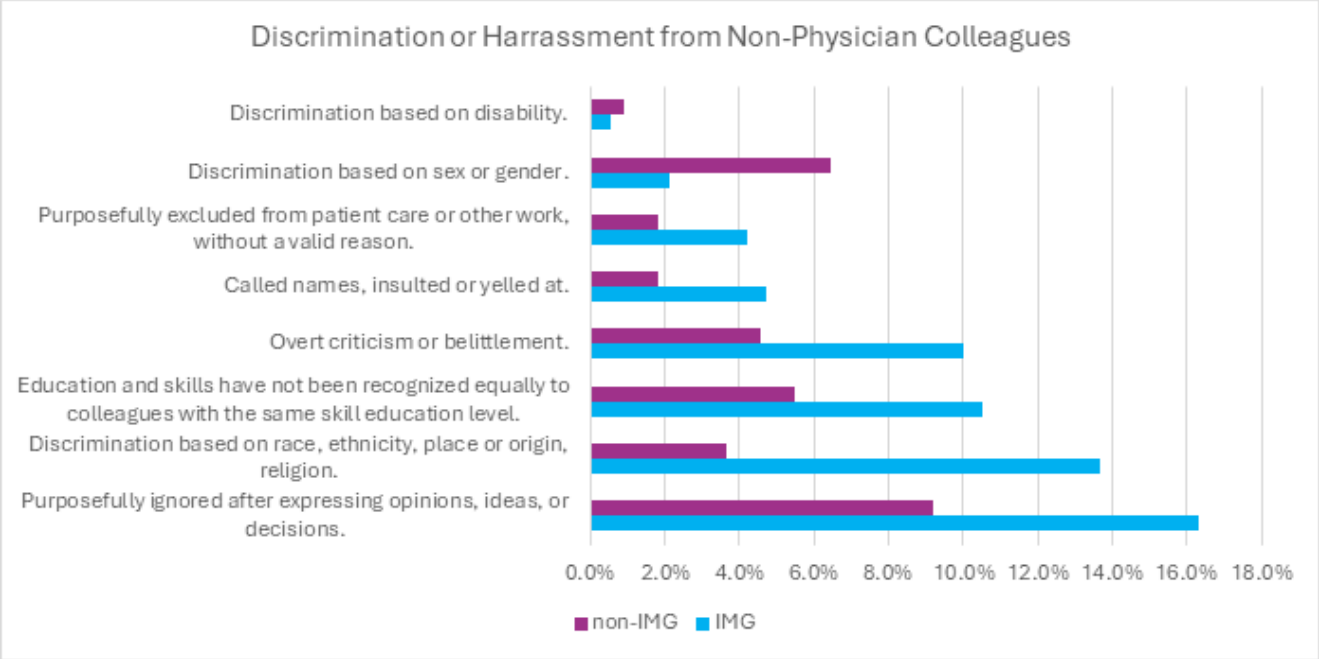
Proportion of each group who experienced discrimination or harassment from any source				
	All	IMG	non-IMG	Sig.*
Any Discrimination	64.5%	64.2%	65.1%	0.872
Patients/Family/Supports	**32.4%**	**26.3%**	**43.1%**	**0.003**
Physicians	40.1%	38.4%	43.1%	0.425
Non-Physicians	23.7%	26.8%	18.3%	0.097
Leadership	28.1%	25.3%	33.0%	0.151
Yes, prefer not to say	**13.0%**	**17.9%**	**4.6%**	**0.001**

**Pearson Chi-Square test*

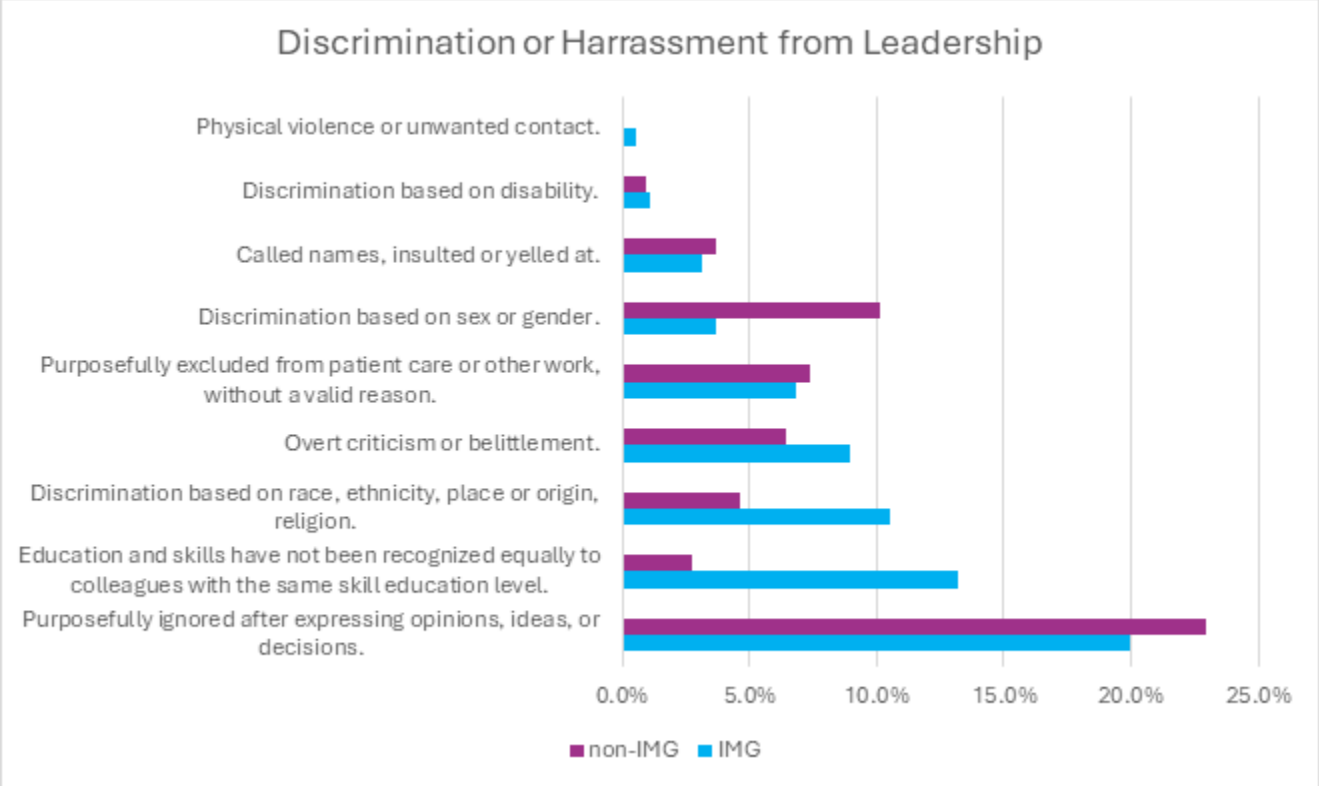
Concerningly, **a large proportion of respondents in both IMG (64.%) and non-IMG (65.1%) groups reported some form** of discrimination or harassment. Non-IMG respondents noted these experiences stemming from patients/family/supports more frequently than IMG respondents. On the other hand, more **IMG respondents reported yes to having had these experiences but preferred not to describe further**, even in the form of this anonymous survey, possibly reflecting a theme of defensive silence.

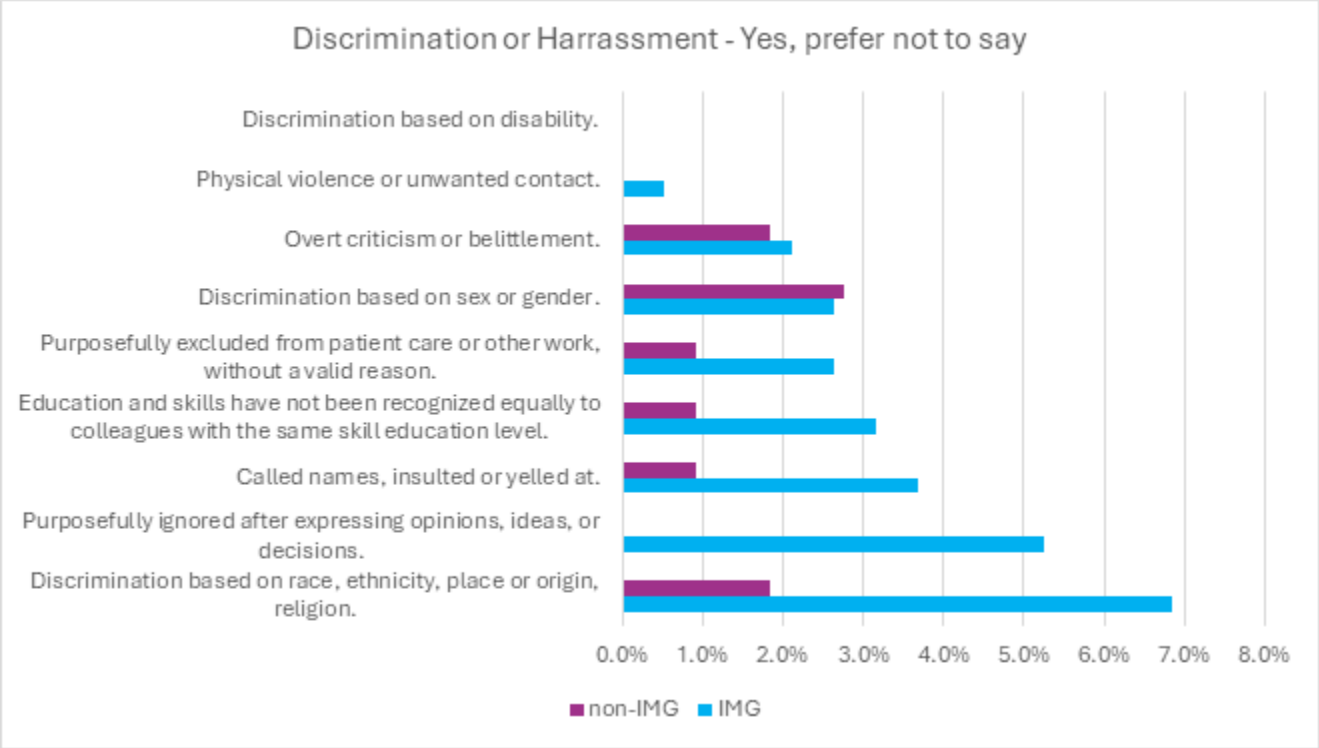

Discrimination or Harrassment from Patients or Family or Supports
Discrimination based on disability.
Purposefully excluded from patient care or other work, without a valid reason.
Physical violence or unwanted contact.
Education and skills have not been recognized equally to colleagues with the same skill education level.
Discrimination based on sex or gender.
Purposefully ignored after expressing opinions, ideas, or decisions.
Overt criticism or belittlement.
Called names, insulted or yelled at.
Discrimination based on race, ethnicity, place or origin, religion.
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0% 35.0%
non-IMG IMG


Discrimination or Harrassment from Physician Colleagues
Physical violence or unwanted contact.
Discrimination based on disability.
Discrimination based on sex or gender.
Called names, insulted or yelled at.
Purposefully excluded from patient care or other work, without a valid reason.
Discrimination based on race, ethnicity, place or origin, religion.
Overt criticism or belittlement.
Purposefully ignored after expressing opinions, ideas, or decisions.
Education and skills have not been recognized equally to colleagues with the same skill education level.
0.0% 5.0% 10.0% 15.0% 20.0% 25.0% 30.0%
non-IMG IMG



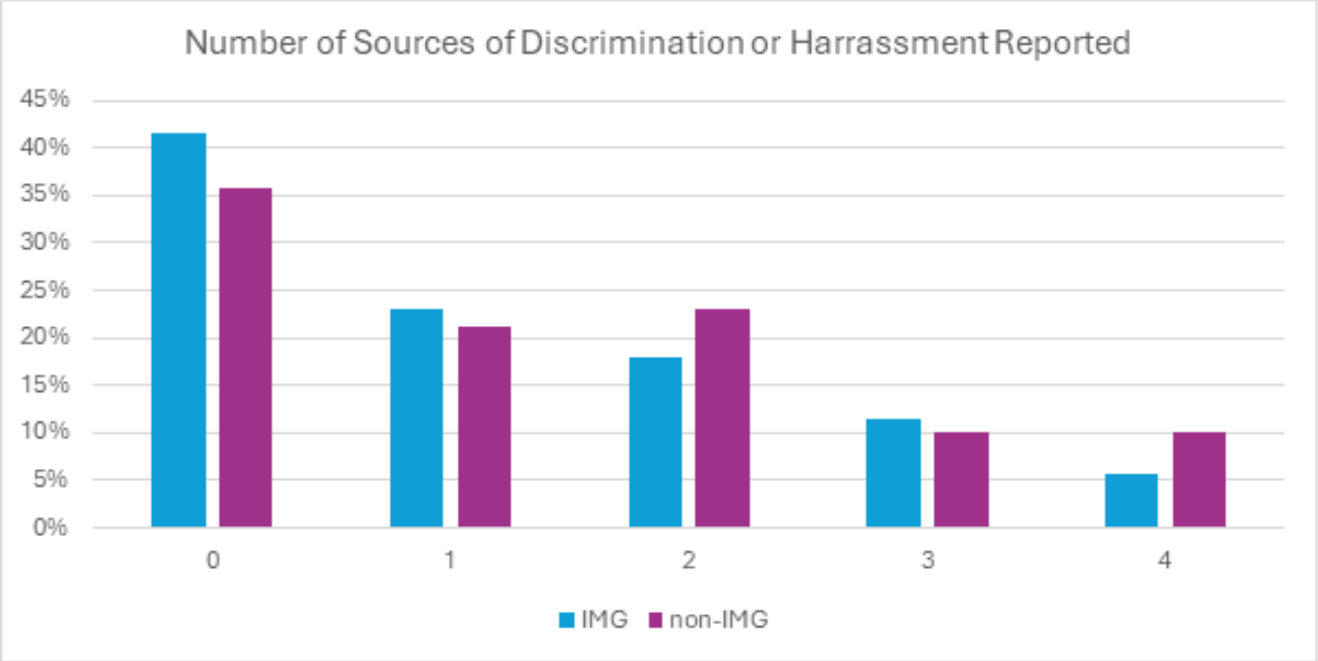
*Physical violence or unwanted contact was 0 in both groups for this category





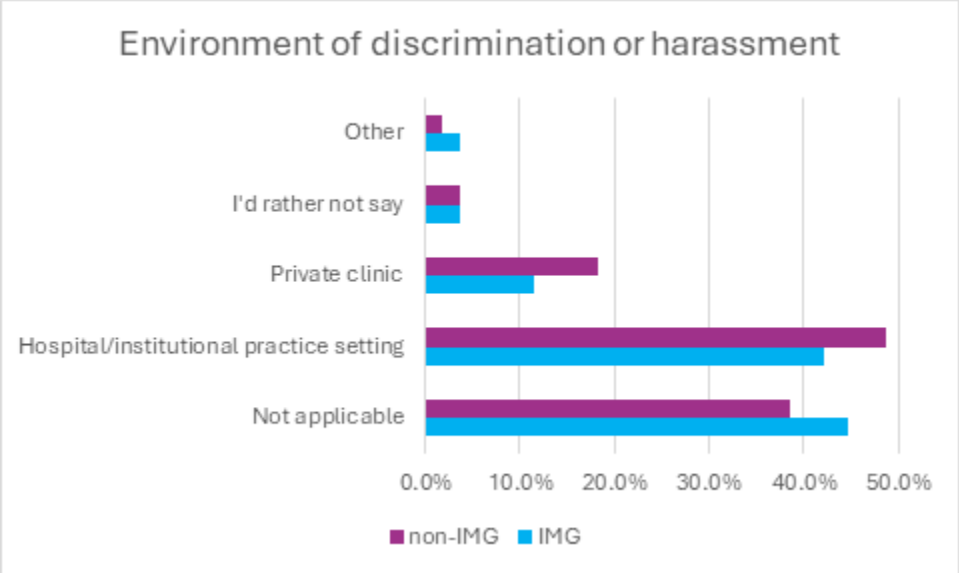
The most frequently reported form of discrimination or harassment from both groups was **Purposefully ignored after expressing opinions, ideas, or decisions**. Additionally, **Discrimination based on race, ethnicity, place of origin, or religion, and Education and skills have not been recognized equally to colleagues with the same skilled education level** were most often reported by IMG respondents. For non-IMG respondents, **Discrimination based on sex or gender** and **Overt criticism or belittlement** were also frequently reported.

There were no significant differences when comparing the number of sources (i.e., from patients, physicians, etc.) of discrimination or harassment between IMG and non-IMG respondents.



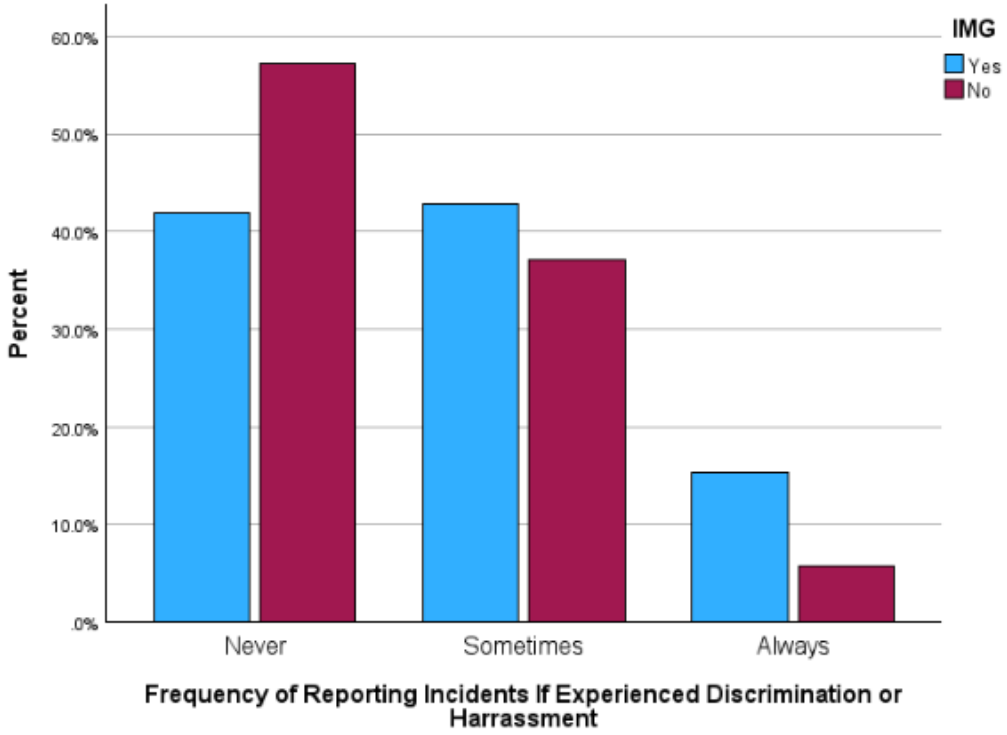
**IMG vs non-IMG by Mann-Whitney U test p=0.199*

- *12." In which environment did you experience discrimination or harassment? Check all that apply."*



For both groups, the most common environment where discrimination of harassment occurred was in the hospital/institutional practice setting.

- *13. "If you experienced, OR observed, any of the incidents above did you tell someone in authority or report the incident(s)?"*



Proportion who selected "Not applicable to me" or left the question blank for the discrimination/Harassment Reporting question: IMG 48.4%, non-IMG 35.8%.

- *14. "Why did you not always report the incidents? Please check all that apply."*

Amongst those who have experienced **discrimination/harassment incidents**, the majority **(88.7%)** did not always tell someone in authority or report the incident(s). This was the case for

both IMGs and non-IMGs. The most common reason cited by **IMG respondents** was being worried there would be **negative consequences** for them. For **non-IMG respondents**, **thinking nothing would be done about it** was the most frequently noted.

- *15. What measures do you think would help prevent and/or respond to these types of experiences?*

IMG priorities:

1. **A trusted, unbiased reporting mechanism for discrimination and harassment with defined accountability and protection from retaliation.**
2. **Strong, enforced policies against discriminatory behaviour.**
3. **Broader education of patients, peers, and supervisors about IMGs and their qualifications and contributions, along with more IMG representation in leadership roles.**

Beyond these top priority needs, IMG respondents highlighted several broader system-level issues:

1. Workplace Culture and Safety

Many comments pointed to the need for a more consistently respectful and psychologically safe environment.

- Safe workplaces grounded in EDI principles
- Regular training and discussions on respectful workplace culture
- Clear boundaries with patients
- Support systems for managing difficult patients and families
- Recognition that physicians must respect each other even under workload pressures

2. Support Structures for IMGs

Respondents described gaps in the supports available to IMGs and their families.

- Supervisors needing training on supportive behaviour
- Supportive mentorship and peer-support or “buddy” systems
- Fair contracts
- Collecting regular feedback from IMGs

Non-IMG respondents identified several factors that cluster into four overarching areas. It is important to note that their responses reflected concerns about discrimination and harassment broadly, not only as they relate to IMGs.

1. Education, Awareness and Culture Change

Respondents emphasized the need for broader education and cultural shifts across the system.

- Education for patients about appropriate behavior towards physicians

- Culture change within leadership roles and institutions
- Training for trainees and supervisors on discrimination and harassment
- Training for all on EDI principles
- Updating or removing discriminatory policies and initiatives
- Recognizing institutional power dynamics as barriers

2. Leadership and Systems Accountability
Many respondents pointed to the role of leadership and regulatory bodies in setting expectations and responding to concerns.

- CPSM acknowledgment of patient/family harassment of physicians
- Clear protocols for reporting discrimination and harassment
- Clear policies and consequences for discriminatory behavior
- Support and representation from leadership
- Leadership organizations needing to work together on this issue
- Addressing the perceived unfairness that patients can report abuse while physicians feel they cannot

3. Professional Standards
Respondents highlighted the importance of consistent professionalism and communication across the workforce.

- Retraining older physicians on professionalism and communication
- Addressing differences in respect and understanding between urban and rural physicians
- Ensuring safe workspaces.

4. Supportive Structures
Respondents identified the need for stronger support systems to help physicians navigate challenging interactions and environments.

- Peer support mechanisms
- Support from colleagues and institutions when dealing with difficult patient or family interactions

Both groups identified **discrimination and harassment as system-wide issues**, not isolated or individual problems. Shared themes included the need for **Clear Reporting Pathways, Accountability, Safe Workplaces, Recognition of Power Imbalances**.

Unique to IMGs is a **Fear of Retaliation and Defensive Silence**, as well as emphasis on **Recognition of IMG Skills and Contributions**.

IMGs held to a Different Standard

- *16. "Do you believe Internationally Trained Physicians/International Medical Graduates are held to a different standard by the system, patients, and colleagues as compared to Canadian-trained physicians?"*

Belief that IMGs are held to a Different Standard					
		Yes	No	Total	Sig*
IMG	N	101	61	162	**0.018**
	%	**62.3%**	37.7%	100.0%	
non-IMG	N	48	53	101	
	%	47.5%	**52.5%**	100.0%	

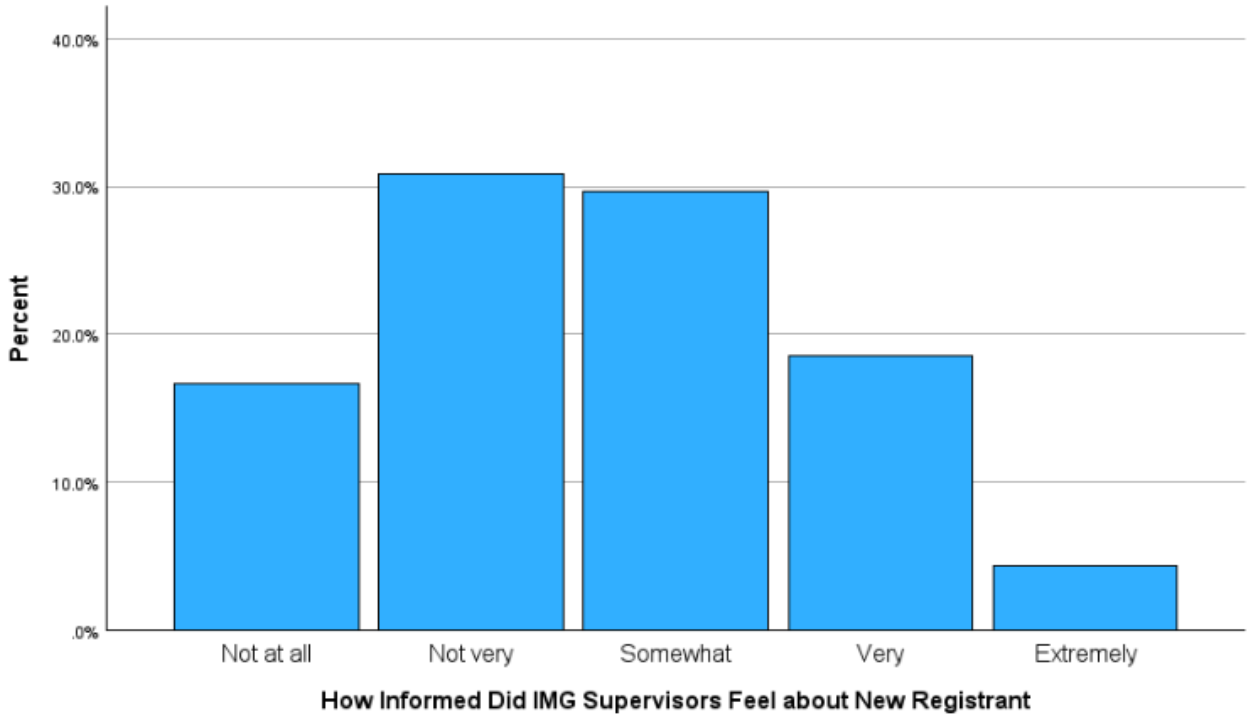
**Pearson Chi-Square. Excludes respondents who selected "Prefer not to say"*

The majority of IMG respondents (**62.3%**) believed that IMGs were held to a different standard, whereas the majority of non-IMG respondents (**52.5%**) did not. This difference in perspectives was statistically significant.

All respondents: Yes =149 (56.7%), No=114 (43.3%). p=0.031* *Chi-Square-test*

Receiving New IMG Registrants into Practice Setting

- *17. "This question is only for registrants who have experience receiving new registrants with international training into their practice setting. How informed did you feel about the individual's background in terms of their training, practice experience, areas of expertise, and areas where support is most required. (Scale 1-5, 1 Not at all informed to 5 Extremely Informed)."*



Graph excludes "not applicable"; All participants: mean rating = 2.63, median rating =3 ("somewhat informed")

On average, respondents indicated they were **not very to somewhat informed about the new IMG registrants that they were receiving** into their practice setting. Of note, this question was not applicable to many of the respondents who were IMGs (53.2% of IMG respondents selected n/a).

Support For Registrants Entering Practice

- *18. "Were any of the following supports and/or resources made available to you when you initially entered practice in Manitoba? If so, did you access them?"*

Supports Were Made Available When Entered Practice (Yes response, excluding "I don't recall" responses)				
	All (%)	IMG (%)	non-IMG(%)	Sig*
Mentor	64.3%	68.3%	56.8%	0.070
Onboarding	45.0%	51.7%	33.7%	**0.007**
Policies	46.3%	48.7%	41.7%	0.296
Community Groups	36.6%	35.8%	38.0%	0.747
Introductions	62.2%	63.9%	59.3%	0.483

**Pearson Chi-Square test comparing IMG to non-IMGs*

Proportion of Registrants who Accessed Supports when Available				
	All	IMG	non-IMG	Sig.*
Mentor	91%	95%	80%	**0.002**
Onboarding	93%	96%	83%	**0.023**
Policies	81%	89%	63%	**<0.001**
Community Groups	69%	79%	50%	**0.006**
Introductions	92%	95%	86%	0.108

**Pearson Chi-Squared Test and Fisher's exact test comparing IMG to non-IMGs*

A significant proportion (36–63%) reported that these supports were **not available** when they entered practice, underscoring a gap that warrants attention. Availability appeared lowest for **community-based supports**. While lower onboarding support among non-IMGs is somewhat expected given the lack of standardized onboarding procedures across all registrants, it is notable that **only 52% of IMGs reported such supports were available**, despite the clear need for this group to have formalized onboarding processes in place.

Non-IMGs accessed these supports less often than IMGs, especially supports related to practice-setting policies and community groups. This may reflect the fact that non-IMGs enter practice with greater familiarity with Manitoba's clinical and community context, reducing their perceived need for these resources.

- *19. "Were there any other valuable support or resources made available to you?"*

Feedback from IMG respondents included not only supports that were made available, but also suggestions for supports. There were 5 main themes, in order of frequency mentioned:

1. Informal Peer Support
- Support from colleagues
- Guidance from mentors
- Connection with other IMGs, both new and established

2. Community-Based Supports
- Community support and social connections
- Spousal or family support
- Community-based financial supports (e.g., bridging loans)

3. Professional and Educational Resources
- CPD and CME opportunities
- Doctors Manitoba supports
- Local hospital or regional staff resources
- CPSM mental health and wellness supports

4. Organized Peer Networks
- Special-interest or identity-based groups (e.g., BIPOC peer support)
- Social events that fostered connection
- Suggestions for an IMG network to link new and established IMGs

5. Practical Tools and Information
- Written materials outlining community resources
- A "who's who" photo guide to help identify key contacts in the medical community

Non-IMG respondents gave less feedback about supports. (Total=12 responses) Their feedback clustered into two main areas.

1. Peer and Colleague Support
- Colleagues
- Occasional supports embedded within group practices

2. Formal Supports
- Assistance from Doctors Manitoba
- Some felt there were minimal supports and need to "make it on your own"

Both groups identified **peer and colleague support to be the most important** whereas there was some inconsistency with regards to availability of formal institutional supports.

IMGs emphasized **informal, relationship-based supports** and emphasize the importance of **community supports for them and their families**. Their suggestions revolved around **strengthening structured mentorship, building IMG-specific networks, and improving access to practical orientation tools** to better support successful integration.

- *20. "In addition to the orientation program and the list of professional expectations CPSM is developing, what other information, resources, support, or processes would benefit registrants who are starting their practice in Manitoba?"*

The answers to this question were more focused on what supports were not available but necessary. IMG respondents identified needs in five key categories.

1. Health System Navigation

Respondents emphasized the need for clearer, more accessible guidance on how to function within Manitoba's health system.

- Practical information on billing, incorporation, and financial processes
- Guidance on diagnostic imaging processes and referral pathways
- Orientation to EMRs and other electronic resources
- Resources specific to navigating the Manitoba health system, including rural-focused materials

2. Professional Development

- Clear pathways for licensure
- Mentorship and direct supervision during early practice
- Training in professionalism, communication, kindness, and non-violent communication
- Education on Manitoba's cultural context, public expectations, EDI, and Indigenous health
- Improved access to CPD/CME and other educational supports

3. Social Support

- Opportunities to connect with other IMGs (new and established)
- Social functions to meet future colleagues
- Networking with community residents
- Regular medical group meetings in rural areas
- Social integration supports

4. Support for Life Outside Medicine

IMGs noted that personal and family stability is essential for successful practice transition.

- Relocation allowances and settlement resources
- Immigration support
- Supports for families
- Wellness supports
- Information on available community services

5. Equity and System-Level Issues

- A clear, unbiased pathway for reporting discrimination
- Information on discrimination and how to address it
- Anti-bullying policies
- Attention to IMGs feeling pressured to accept poor working or living conditions
- Recognition of perceived discrimination from governing institutions
- Stronger collaboration between institutions to provide coordinated supports
- Regular check-ins during the transition period

Non-IMG respondents identified a broad set of supports that would strengthen integration of new registrants entering practice in Manitoba. These clustered into five major domains.

1. Social Supports

Respondents most frequently emphasized the importance of non-clinical supports that help registrants and their families build stability and belonging in Manitoba.

- Access to support groups including special-interest or religion based
- Support and connection with the local community including for families
- Centralized information on community resources
- Mentorship opportunities
- Physician networking events
- Peer IMG networks

2. Health System Navigation

- Clear information on referral processes
- Centralized information on community resources
- Region-specific resource guides
- Orientation to diagnostic imaging processes

3. Regulatory Oversight

- CPSM check-ins with IMGs to ensure quality and support
- Improved vetting to ensure IMGs meet practice standards
- RHA leadership actively welcoming and orienting IMGs

4. Professional Development

- Education on diseases more common or unique to Canada
- Training in challenging clinical areas such as substance use disorders
- Training on opioids and benzodiazepines
- Support for managing physician–patient conflict

5. Cultural Competence, EDI and Communication Skills

- Training on culture, EDI, and Indigenous health

Both groups emphasized the importance of resources relating to **Health System Navigation and Social Supports**. IMGs in particular emphasized supports relating to **Life outside of Medicine**, including spousal integration and relocation assistance, and pointed to **Equity** concerns that could affect the experience of entering practice. Non-IMGs focused more on **Regulation and System Oversight**, to ensure new registrants met expected standards.

Reasons for Coming to and Staying in Manitoba

- *21. "Did you come to Manitoba specifically to practice medicine? (Yes/No)"*

All participants: Yes = 68.2%, No = 31.8%.

Proportion who came to MB specifically to practice medicine		
IMG	non-IMG	Sig.*
83.7%	41.3%	<0.001

**Pearson Chi-Square Test*

While most IMGs (83.7%) moved to Manitoba to practice medicine, fewer non-IMGs (41.3%) did so, though this remains a substantial proportion of respondents.

- *22. "Thinking about what makes you stay in Manitoba … please rate the following from not important at all to very important, or not applicable"*

The following tables present the importance ratings on a 1–6 scale, where 1 indicates "not applicable" and 6 indicates "very important."

Rating of Reasons for Staying in MB	
	All (mean)
Established family and community.	5.34
Personal	4.29
Delivering care to a particular community.	4.14
Professional or academic responsibilities (i.e. Research, teaching).	3.80
Obligation to complete Return of Service agreement.	2.31
Citizenship reasons (helping family visit, work or immigrate to Canada).	1.77

Comparison between IMGs and non-IMGs for Reasons for Staying in MB			
	Means		
	IMG	non-IMG	Sig*
Established family and community.	5.24	5.53	0.064
Personal	4.31	4.27	0.870
Delivering care to a particular community.	4.30	3.85	**0.032**
Professional or academic responsibilities (i.e. Research, teaching).	3.93	3.59	0.127
Obligation to complete Return of Service agreement.	2.75	1.54	**<0.001**
Citizenship reasons (helping family visit, work or immigrate to Canada).	2.05	1.29	**<0.001**

**Independent Samples T-Test*

Across respondents, the most important reasons for staying in Manitoba were **Established family and community ties**, followed by **Personal factors** and **Delivering care to a particular community**. Comparisons between IMGs and non-IMGs show a few statistically significant differences: **IMGs placed greater importance** on **Delivering care to a particular community**, **Return-of-Service obligations**, and **Citizenship-related factors**. Non-IMGs rated family and community ties slightly higher, though this difference did not reach statistical significance.

- *23*. "*Were there any other reasons for staying? Please list them.*

Responses from IMGs clustered into four main themes, ordered from most frequently cited.

1. Family and Personal Reasons

- Being now settled with family
- Strong pre-existing family ties
- Manitoba as a good place to raise children

2. Community Integration

- Feeling part of the community
- Commitment to serving the community
- Appreciation for local residents and staff who helped them establish themselves

3. Career and Professional Meaning

- Career satisfaction
- Interesting and rewarding patient population
- Remuneration and grant-based incentives

4. Location and Lifestyle

- Positive views of Manitoba and its communities
- Winnipeg seen as a good place to live

- Lower cost of living
- Shorter commute times
- Good work life balance

Non-IMG responses generate the same themes.

1. Family and Personal Reasons
- Being settled with family
- Strong family ties
- Manitoba as a good place to raise children

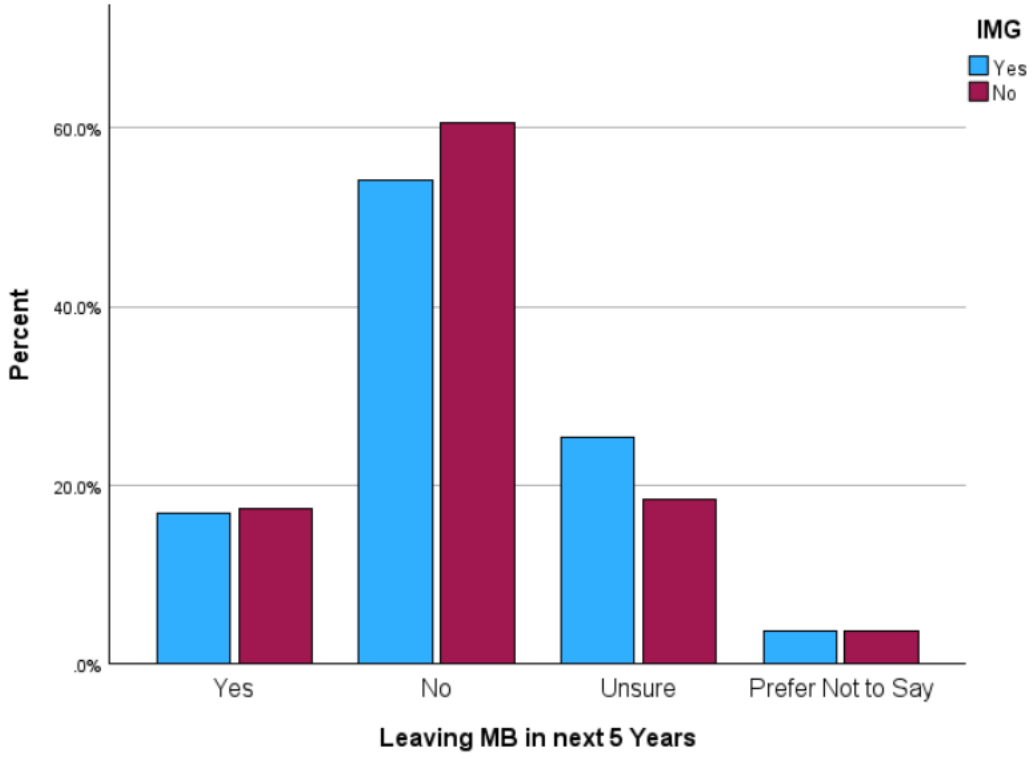
2. Community Integration
- Commitment to their community
- Feeling part of the community
- Being born in Manitoba

3. Career and Professional Meaning
- Career satisfaction
- Remuneration and financial incentives
- Familiarity with the Manitoba health system
- Interesting patient population
- Availability of patient care resources
- Incentives from Doctors Manitoba
- Positive work environments

4. Location and Lifestyle
- Low cost of living
- Short commute times
- Difficulty re-establishing elsewhere
- Financial ties that anchor physicians to the province

Across both IMG and non-IMG respondents, the most frequently cited reasons for staying in Manitoba are rooted in **family stability** and a sense of **community belonging**. Both groups also highlighted **career satisfaction** and Manitoba's **lifestyle advantages**, including affordability and manageable commutes. Some differences were observed in how these reasons were emphasized: IMGs more often described **community support and belonging** as central to their decision to stay, while non-IMGs more frequently cited **financial ties** and being **born or long-established in the province**. Overall, retention for both groups is driven primarily by **personal and community factors**, supported by professional fulfillment and Manitoba's livability.

- *24. "Are you considering leaving Manitoba within the next five years?"*



17.1% of respondents are considering leaving Manitoba within the next five years. The proportions of those considering leaving are not significantly different between IMG (16.8%) and non-IMG (17.4%) respondents (p = 0.580).

Respondents provided free text responses to expand on reasons for considering leaving the province. Across both IMGs and non-IMGs, workplace culture, health-system dysfunction, and lifestyle/family factors were cited as significant factors:

- Toxic or unsupportive work environments
- Dissatisfaction with leadership
- Under-resourced health-care settings
- Burnout
- Lifestyle factors, including weather and perceptions of better opportunities elsewhere
- Family relocation or retirement

IMG respondents raised several concerns unique to their group, including **challenges obtaining permanent residency, licensing barriers, restrictions on practice roles, and experiences of discrimination.**

General comments about the transition period

- *25. "Is there anything else you would like to share about your experience?"*

There was a wealth of information and ideas from this question with an especially large number of responses from IMG respondents.

Responses highlighted variability in practice culture. Some physicians described supportive colleagues, accessible mentors, and effective onboarding. Others described isolation, lack of feedback, poor orientation, hierarchical power dynamics, exclusion, differential treatment, and environments perceived as unsupportive or exploitative. This variability is important because it suggests that positive transition-to-practice experiences currently depend too heavily on local circumstances rather than consistent expectations across the system. Onboarding, mentorship and peer support are clear protective factors, but current offerings are also inconsistent.

Here are key themes with associated quoted examples:

KEY ISSUES IDENTIFIED (with major contribution from IMG respondents; italicized text are dominant themes unique to non-IMG respondents)

A. Challenges in a Vulnerable Transition Period

1. Financial strain
    a. Multiple exams with long waits between retakes, low-income bridge employment, young families, high cost of living
2. Isolation
    a. Away from family in home country
    b. Training location away from family
3. Emotional Distress
    a. Immigration stress

"one of the most difficult things I have done in my career"
"I cried almost every day… no one thought I belonged"

B. Gaps in Mentorship, Professional Integration and Alignment

1. Inconsistent Mentorship and Early Career Support
    a. Mentorship consistently identified as an important protective factor
    b. Availability, engagement, location, and supportiveness of mentors are variable
    c. Reports of negative supervisory experiences perceived as inequitable or discriminatory
2. Barriers to Professional Integration and Peer Networks
    a. Reliance on informal networks (e.g. for specialist referrals)
    b. Uneven access to peer support, peer support groups
3. *Variability with registrant alignment with Practice Expectations and Professional Standards*

    a. *Scope of practice expectations*
    b. *Cultural competence (e.g. LGBTQ inclusive care, Indigenous health awareness)*
    c. *Billing standards*
    d. *Gaps may reflect limited formal orientation to Canadian practice expectations and prior training contexts*

"there are good people here who see your talent and mentor you — but you have to find them"
"supervisors … were respectful, empathetic, and clear in their expectations… eased my transition."
"I believe it is important to connect … with other IMGs… value in their shared experience that can help ease the transition into practice"
"lack of effort to connect sites locally — would help a lot with collegiality"
"family docs who will not provide gynaecological care (other docs in the clinic have had to take this over for their patients)"
"I honestly also see a lot of over billing so I think this should also be taught more formally"

C. Challenges in Practice Readiness compounded by Working Conditions and Isolation

1. *Variability in Early Practice Readiness*
    a. *Observed inconsistencies in certain clinical areas (e.g. gynecology), reliance on peers for informal training*
    b. *Patient safety concerns during early practice especially where physicians are in high demand, limited resource, and independent settings*
        i. *Variability in medical training pre-immigration and insufficient rural/remote training in current IMG programs*
        ii. *Mismatch between practice demands and support structures*
2. Professional and Social Isolation
    a. Reports of workplace and community perceived to be unwelcoming
    b. Family and social integration barriers
    c. Placements away from family

"they start out less prepared for practice… but are thrown into the most challenging locations"
"If CPSM wants to keep the public safe, it needs to have better diligence about deciding who is qualified, especially when working in remote areas."
"lack of resources to provide… services"
"not readily welcome by a community that is very closely knit"
"wife could not find work… ended up leaving town"
"financially… expensive… lived far from family"

D. Perceived inequities on an interpersonal, institutional, and structural level

1. Interpersonal
    a. Reports of discrimination, harassment, being held to a different standard
    b. Perceived lack of trust and professional credibility from colleagues and patients

2. Institutional
    a. Concerns regarding fairness and transparency of institutional processes
    b. Perceived uneven access to opportunities, training, advancement
    c. Perception of being undervalued by leadership
3. Structural
    a. Uniform assessment and credentialing processes may not fully account for prior training, clinical experience and specialty expertise

"held to different standards"
"patients… respect doctors graduated from Canada more"
"IMGs are treated differently… undermine their value"
"racism… abusive chief of staff"
"RHAs have been mean- I feel excluded and unwelcome, never complimented or cheered on in … years."
"I have no access to university resources and training opportunities due to bureaucracy"
"IMGs should be assessed in their area of practice than creating hurdles asking them to clear exams that has no relevance to their practice."
"after 4 years of practice in Manitoba… I should be granted full licensure without all these conditions…costly…"
"the expectation to study like a resident again and redo exams or work under supervision etc, discourages them."

E. Identified Protective Factors

1. Psychological safety
    - Inclusion, appreciation, being valued, being needed, trust from colleagues and patients
2. Sense of belonging
    - Welcoming community and RHA
    - Family and spousal integration into community
    - Supportive colleagues, supervisors and mentors
    - Peer Networks including IMG to IMG
3. Motivated by desire to reciprocate to community and work team which provided IMG with opportunities and welcoming attitude

"Amazingly welcomed by my future hospital colleagues"
"The medical community was very accepting of my training and made the transition very easy."
"Living and practicing here with my family, in a stable and welcoming environment, has greatly contributed to my professional satisfaction and personal well-being."
"I love the community I am serving"
"my wife also started working at the same time… Other colleagues have struggled… because their wives could not find work"
"I have had a good experience and believe its time to give back"

Recommendations from respondents

1. **Support for transition period**
    a. Financial loans
    b. Vocational counseling and support (pre-entrance to IMG programs)
    c. Newcomer/Immigration support

2. **Formalize and enrich mentorship, peer networks, and professional integration**
    a. Formal mentorship
        i. Local mentor to help with practice navigation
        ii. Established IMG mentor with shared lived experience
        iii. Provide mentors with protected time and fair compensation
    b. Formalize professional community network integration
        i. Handbook with names, contacts, photos
        ii. Orientation to referral processes and network
    c. Support peer networks for social integration
        i. Community/RHA hosted social events to welcome and introduce IMG
        ii. Social media interest and support groups
    d. Reassessment of current IMG onboarding programs
        i. Structured onboarding
        ii. Supervision
        iii. Mentorship
        iv. Progressive autonomy and check-in may be a missing piece

3. **Improve Working Conditions**
    a. Ensure appropriate training and competency assessments prior to rural and remote placements
    b. Collaborate with system partners (RHAs, Shared Health) to ensure availability of clinical supports and backups in place for IMGs especially in remote and under resourced areas (e.g. access to calling a senior colleague, specialists, without the usual pushback typically seen at tertiary centers)
    c. Supervision models in challenging high demand under resourced areas
    d. Prioritize keeping families together
    e. Family integration supports (social, employment)

4. **Cultural Shift: System wide EDI and IMG integration initiatives**
    a. Initiatives for physicians, leaders, and staff to improve understanding and perceptions of IMGs
        i. More IMGs in leadership roles
        ii. Training and monitoring of those who play vital roles in new IMG integration
    b. Anti-discrimination policy with clear non-biased pathways for reporting and accountability processes
    c. Initiatives to improve public perceptions of IMGs and establish trust
    d. Ensure transparent and high-quality assessment and licensure requirements for IMGs to help build public trust

i. Current perceptions of undue government influence potentially impacting standards of competency

5. **Ensure fairness and respect from regulatory bodies and leadership**
    a. Fairness in policies towards IMGs from different countries
        i. Perception of unfairness with fast-tracked IMGs from e.g. US, UK
    b. Recognize unique backgrounds of IMGs and avoid one size fits all assessment pathways
        i. Practice relevant workplace-based assessment models > RCSPC requirements
    c. Promote leadership accountability, transparency, and renewal mechanisms
    d. Strengthen feedback and accountability
        i. Regular IMG experience surveys
        ii. Transparent response systems
        iii. Anonymous reporting channels
    e. Institutions working together to support IMGs, avoid conflicting or redundant processes
        i. E.g. CPSM, RHAs, Shared Health, University, Government

Part III – Deliverables

Recent work in registration and licensing

Across both focus group sessions, participants described what they perceived as excessive bureaucracy and delays in obtaining registration, licensure and employment, such as difficulty securing job offers, complex paperwork, additional examination and assessment requirements, and system fragmentation sometimes leading to multi-year delays in starting practice. Survey data indicated that registrants often experience uncertainty, delays, inconsistent or inaccessible information, and significant administrative and financial burden in the registration process.

These findings signalled a need for clear published information about registration and licensure pathways, to examine pathways for efficiency and simplification opportunities where appropriate. Findings also support continuing our already ongoing work to modernize our licensure pathways to better enable recognition of demonstrated competencies and accommodate differing scopes of practice, while ensuring safe integration into Manitoba's healthcare system.

CPSM has been undertaking significant recent regulatory modernization efforts, particularly in parallel with and informed by the efforts of the IMG Working Group. These have been aimed at reducing barriers that previously affected many IMGs and ITPs:

- The IMG Program began counting Clinical Assistant experience toward MLPIMG recency of practice requirements in 2020.
- Removal of the LMCC requirement in 2023 (this work predated the IMG Working Group).
- Recognition of Royal College SEAP pathways to full registration in 2023.
- Recent amendments in 2025 recognizing American Board-certified physicians for full licensure.
- The creation of the Provisional (Other Approved Training) Class in June of 2026.
- The PRA MB-EM (Emergency Medicine) was established in June of 2026.

These changes reflect a deliberate shift toward competency-based regulation and away from requirements that may have limited evidence of added public-protection value.

The most significant current evolution is CPSM's new Approved Jurisdiction framework (approved by Council in August of 2026). CPSM is moving toward a model where jurisdictions can be formally recognized based on factors such as:

- Undergraduate medical education standards.
- Postgraduate training accreditation.
- Certification systems.
- Regulatory oversight.
- Continuing competence requirements.
- Governance and public protection safeguards.

Under this approach, physicians from jurisdictions deemed substantially equivalent may become eligible for direct or expedited licensure pathways. This aligns Manitoba with a broader pan-Canadian movement toward approved-jurisdiction models already adopted elsewhere in Canada.

Finally, CPSM is engaged in significant revision to our website materials to enhance accessibility.

The New Orientation Program

One of the Working Group's primary deliverables was the development of a new orientation program for physicians entering practice in Manitoba. This was accomplished, and the first session was delivered in January of 2026. It is delivered over 2 days, in-person.

The orientation was designed to provide practical, Manitoba-specific information that supports safe, confident, and effective transition into practice. Although developed in response to the experiences of IMGs and ITPs, the orientation is relevant to any physician entering a new Manitoba practice environment, particularly those with limited prior experience in the province's health system, regulatory framework, and practice expectations. With this in mind, CPSM is now considering expanding this offering to all new physician registrants.

The purpose of the orientation is to help physicians understand the systems, standards, relationships, and professional expectations that shape medical practice in Manitoba. The program is designed to reduce uncertainty, support patient safety, promote professionalism, and help physicians connect with the practical resources and supports they need as they enter practice.

The orientation program is organized around topics identified as important to safe and effective entry into practice. These include the structure of Manitoba's health system; CPSM's role, standards, and expectations; the complaints and investigation process; duty-to-report obligations; cultural safety and reconciliation; interprofessional communication; safe prescribing; documentation; referrals and transfers of care; billing and remuneration models; practice models; physician wellness; and local practice-setting expectations.

The orientation also provides an opportunity to introduce physicians to the broader culture of medical practice in Manitoba. This includes expectations related to respectful interprofessional relationships, patient-centred communication, trauma-informed care, working with Indigenous patients and communities, responding to discrimination or harassment, seeking support, and understanding the responsibilities that come with professional self-regulation.

The specific agenda items are as follows:

- CPSM Structure and Self-Regulation
- Standards of Practice and Good Medical Care
- Patient-Centred Care and Communication
- Safe Prescribing
- Reconciliation and Anti-Indigenous Racism

- Equity, Access, and Participation
- Documentation and Medical Records
- Workplace Culture and Collaborative Practice
- Manitoba Healthcare System Overview
- CMPA Resources and Professional Supports

The orientation sessions delivered to date have been very well received and highly engaging. Participants have had meaningful opportunities to interact directly with the people who work at CPSM, better understand the organization and its role, and make personal connections that help demystify the regulator and support a more approachable and trusted regulatory relationship.

The orientation program is being treated as an evolving program rather than a one-time product. Refinements have been made after each iteration.

CPSM is considering how it can evaluate whether the orientation improves participants' understanding of Manitoba practice, CPSM expectations, reporting pathways, cultural safety obligations, and available supports. To date, participant feedback has been very positive based on in-person comments and CPD surveys. CPSM is considering a subsequent survey after a period of six months following completion of the orientation.

The New Standard of Practice for Entering Practice

The Working Group heard that orientation, mentorship, supervision, feedback, and workplace support are often inconsistent across practice settings. Some physicians described supportive and collegial environments, while others described isolation, unclear expectations, lack of feedback, discrimination, racism, harassment, or fear of raising concerns. These experiences showed the need for a clear regulatory standard that sets expectations for physicians entering practice and for the physicians, leaders, and teams receiving them.

To this end, a second major deliverable of the Working Group was the development of a new Standard of Practice for Entering Practice in Manitoba. The Standard responds to a central finding of the Working Group: successful entry into practice is not only a matter of individual physician competence or registration status. It also depends on whether physicians are supported to understand local systems, regulatory expectations, clinical workflows, team relationships, and the professional culture of the practice environment they are entering.

A copy of the new Standard of Practice and Contextual Information is attached as **Appendix B**.

The Standard is grounded in the professional obligations reflected in CPSM's Code of Ethics and Professionalism. Those obligations include practicing competently, communicating respectfully, supporting continuity and quality of care, treating colleagues and patients with dignity, responding appropriately to concerns, and contributing to a professional culture that supports patient safety. The Standard translates those broad ethical and professional duties into more

specific expectations for physicians entering or receiving physicians into a new practice environment.

Pursuant to the Standard, physicians entering a new practice environment are expected to take reasonable steps to understand the local systems, standards, resources, and expectations relevant to their practice. This includes becoming familiar with CPSM standards and practice directions, local clinical workflows, documentation and prescribing expectations, referral and transfer processes, communication norms, available supports, and any supervision, monitoring, or mentorship requirements that apply. Physicians are also expected to ask questions, seek feedback, participate in orientation, and identify areas where they need additional support.

The Standard also recognizes that successful integration is a shared responsibility. Physicians, leaders, and teams receiving a new colleague should provide clear expectations, practical orientation, reasonable access to policies and procedures, opportunities for questions, constructive feedback, and appropriate supervision or mentorship where required. Receiving environments should not assume that a physician's prior experience automatically includes familiarity with Manitoba's health system, CPSM expectations, local documentation and prescribing practices, practice management processes, or interprofessional team norms.

The Standard emphasizes that physicians entering or receiving colleagues into a practice environment must contribute to respectful interprofessional relationships. Respectful relationships include clear communication, appropriate recognition of the roles and expertise of others, timely response to concerns, and conduct that supports trust within the team. This expectation is important for patient safety and for creating practice environments where new physicians can learn, ask questions, and raise concerns without fear of humiliation or retaliation.

The Standard clarifies that orientation should be practical and relevant to the physician's actual practice setting. Where supervision, monitoring, mentorship, or feedback arrangements are required or appropriate, they should be clear, constructive, and proportionate to the physician's role, training, experience, and registration status. Feedback should be provided in a way that supports learning and improvement, identifies concerns early, and helps physicians meet expected standards of practice.

The Standard addresses the conditions needed for physicians to enter practice safely and successfully. It reinforces expectations related to cultural safety, anti-racism, respect, and psychological safety. Physicians and practice environments should take concerns about discrimination, harassment, differential treatment, and retaliation seriously, and should support accessible pathways for raising concerns. These expectations are consistent with the Working Group's findings that workplace culture directly affects integration, retention, physician well-being, and patient care.

Moving forward, the plan is for CPSM to communicate the Standard clearly to physicians, supervisors, medical leaders, employers, and health-system partners. This will include plain-

language guidance, scenarios, resources, and onboarding tools that can help translate the Standard into practice as part of the Contextual Information attached to the Standard.

CPSM will further explore how the Standard can inform supervision expectations, practice administration expectations, physician health and wellness supports, and future work with health-system partners on respectful workplaces and retention.

Part IV - Next Steps and Recommendations

The Working Group's findings point to a practical path forward, with significant progress having already been accomplished. CPSM has already taken important steps as described in this Report. The next phase should focus on implementation, evaluation, communication, and continued collaboration with external partners.

The recommendations below are organized into actions within CPSM's control, actions requiring collaboration with partners, and longer-term policy or system considerations.

Actions within CPSM's control

1. **Continued maintenance and evaluation of the new CPSM orientation program.**

   CPSM has established a two-day mandatory standardized orientation curriculum for newly registered physicians who have less than one year of practice in Canada (including residency or fellowship training). The program is described above in this report, and prioritizes topics that registrants identified as needs as per the survey.

   Recommendations:

   a. The program should be maintained and potentially expanded to include all physicians entering independent practice in Manitoba. It is important that content be continuously updated to remain relevant and addresses known pitfalls manifesting early in practice.

   b. CPSM should establish an evaluation framework to assess whether the orientation was useful, and improves understanding of Manitoba's health system, CPSM expectations, reporting pathways, cultural safety obligations, and available supports. This should include circulating a needs assessment survey for orientation needs and feedback about the orientation delivery, at regular intervals.

2. **Implementation and operationalization of the Standard of Practice for Entering Practice in Manitoba, including developing helpful Contextual Information.**

   a. CPSM should devote resources to the implementation and operationalization of the new Standard of Practice. Implementation should include clear communication to registrants, supervisors, medical leaders, employers, and external partners.

   b. CPSM should also develop practical tools to support implementation, such as plain-language guidance, onboarding checklists, helpful scenarios, frequently asked questions, and examples of reasonable orientation, supervision,

mentorship, and feedback arrangements. This can be included in the Contextual Information or as part of other CPSM programs and initiatives.

c. CPSM may further develop accessible resources that explain important regulatory expectations in practical terms, which could include podcasts, videos, modules, or advice documents. These should address topics raised in the survey responses. Priority topics should include CPSM's role, professional self-regulation, standards and practice directions, duty-to-report obligations, CPSM's accountability processes, and continuing professional development. They should also address prescribing, documentation, practice locations, and ways to seek guidance. These resources should be prepared for registrants who may be unfamiliar with Manitoba's regulatory system and should also be useful to Canadian-trained physicians entering new practice settings.

3. Continued review of registration pathways and supports through a fair-registration and patient-safety lens.

a. CPSM should continue to review registration pathways and supports affecting IMGs and ITPs, including areas where requirements may be difficult to understand, duplicative, inconsistently communicated, or not clearly connected to risk. Any review should maintain appropriate safeguards for patient safety while identifying opportunities to reduce unnecessary barriers, improve transparency, and better recognize prior training and experience where appropriate.

4. Expansion and improvements respecting CPSM's mentorship requirement

Mentorship for 1-year is required for provisional registrants who have participated in the MLPIMG or a PRA program in Manitoba. The University of Manitoba administers the Mentorship Program, which include orientation and training for mentors, and has a structured program over the course of the year. Mentorship is designed to be supportive and focused on provide help entering practice in Manitoba.

Recommendations:

a. This program functions well, but it would be useful to find ways to make it accessible to all registrants entering practice in Manitoba or to develop a similar program for this purpose. For example, ITPs from recognized or approved jurisdiction who do not require further training or assessment presently cannot avail of the mentorship program, which would be of benefit to them.

b. There is also some suggestion that enhanced mentorship training might be helpful. Standardized training for mentors including professional expectations on providing guidance and feedback and maintaining a respectful and supportive work environment is essential.

c. CPSM should ensure a quality assurance mechanism is established for mentorship including evaluations and feedback loops.

d. Reasonable measures should be taken to ensure mentors are appropriately compensated to recognize the time and effort involved in supporting IMG and ITP integration, and to incentivize high-quality, consistent mentorship.

5. CPSM's supervision requirement

a. Survey and focus group findings indicate required supervision could be improved by making it more structured, consistent, and explicitly developmental rather than simply a condition attached to provisional registration. While CPSM does have a workshop for practice supervisors, this report suggests that supervisors should receive clearer preparation about their role, the registrant's background and pathway, CPSM expectations, and the purpose of supervision during the transition period. Standardized training for supervisors including professional expectations on providing guidance and feedback and maintaining a respectful and supportive work environment is essential.

b. Consideration should be given to having supervision plans include early orientation to the local practice setting, regular scheduled check-ins, direct opportunities for observation and feedback, and clearer documentation of progress, concerns, and supports provided.

c. The supervision process should also distinguish between oversight for patient safety and mentorship for integration, so that registrants receive both appropriate accountability and practical support.

d. CPSM, employers, and practice sites should work together to ensure that supervision quality is monitored, supervisors are supported, and registrants have a safe way to raise concerns where supervision is inconsistent, unclear, or not meeting its intended purpose.

e. CPSM should ensure a quality assurance mechanism is established for practice supervision including evaluations and feedback loops.

f. Reasonable measures should be taken to ensure supervisors are appropriately compensated to recognize the time and effort involved in supporting integration, and to incentivize high-quality, consistent mentorship.

6. Data tracking and quality-improvement cycle.

a. CPSM should use the survey results as a baseline for future evaluation. In this regard, CPSM should continue to engage registrants with lived experience of entering Manitoba practice, as well as supervisors, mentors, medical leaders, and receiving practice environments. Continued engagement will help CPSM assess whether the orientation program and Standard of Practice are meeting their intended purposes, identify emerging issues, and ensure that future improvements are grounded in practical experience.

b. Over time, CPSM should monitor orientation participation, participant feedback, registrant satisfaction, retention indicators, themes from complaints or practice-support matters, and recurring questions from new registrants.

c. Improved data collection will help CPSM assess whether its interventions are reducing uncertainty, supporting safe practice, and improving the experience of registrants entering Manitoba practice.

d. The orientation program, Standard of Practice, survey findings, and Working Group recommendations should not be viewed as the end of CPSM's work on IMG and ITP integration. They should form the foundation for an ongoing cycle of implementation, evaluation, learning, and refinement.

<u>Actions requiring collaboration with health-system partners and practice settings</u>

1. Collaborate with partners to strengthen orientation, onboarding, mentorship, and local practice supports.

The findings in this report align with the literature review in several respects. The survey findings confirm the literature's central conclusion that successful transition into a new practice environment depends not only on the individual physician's adaptability or competence, but also on the quality of the receiving system.

Consistent with the reviewed studies, respondents identified practical orientation to local systems, clear expectations, mentorship, constructive feedback, collegial relationships, culturally safe practice environments, and community belonging as key conditions for successful integration.

Recommendations:

a. CPSM should collaborate with Shared Health, regional health authorities, medical leaders, employers, supervisors, and other practice sites and partners to promote and develop support programs and resources including:

i. more consistent system and site-level onboarding, orientation, and mentorship for physicians entering new practice environments,
ii. peer networks,
iii. supports for life outside medicine (resources for hobbies, spouse and children), and
iv. facilitated integration into communities and social events.

This should include clearer expectations for local orientation, practice-setting introductions, access to policies and procedures, structured feedback, and appropriate mentorship or supervision.

b. Promote protective factors, including valuing, trust, belonging, appreciation, through leadership training and workplace culture initiatives.

c. Encourage health system partners responsible for practice placements to prioritize family unity as a key factor that supports IMG wellbeing and successful retention.

2. Ensure safe and sustainable practice conditions

a. Encourage RHAs to assess site specific practice-readiness before placing IMGs new in practice in high-demand or under-resourced environments.

b. Integrate education on employment rights into orientation and onboarding including work hour protections, vacation entitlements, leave policies, to reduce burnout and address perceptions of inequity.

c. Promote awareness of available supports including physician wellness programs and avenues for confidential advice when workplace issues arise.

d. To address professional isolation, encourage team-based practice settings with supported progressive autonomy in rural practice placements whenever possible.

3. Collaborate on respectful workplace, reporting, and anti-discrimination supports.

The Working Group's findings show that discrimination, racism, harassment, differential treatment, and fear of retaliation affect transition to practice, physician well-being, and retention. These findings mirror the literature on racism and discrimination by showing that workplace culture, psychological safety, reporting confidence, and the extent to which IMG skills and experience are recognized can materially affect integration, well-being, and retention.

Recommendations:

a. CPSM should work with health-system partners to clarify reporting pathways, reduce barriers to reporting, support psychologically safe processes, and reinforce expectations for respectful and culturally safe practice environments.

b. Addressing systemic barriers and discrimination and promoting equity should include:
    i. Embed equity-focused expectations into professional standards, emphasizing respectful workplace culture and recognition of diverse training backgrounds.
    ii. Implement education and awareness initiatives for registrants, leadership, and the public that highlight IMG training pathways, assessment and licensure requirements, competencies, successes, and invaluable contributions to Manitoba's health system.
    iii. Implement anti-discrimination policies with clear non-biased pathways for reporting and accountability of processes.
    iv. Promote a culture of collaboration among leadership health institutions working together to support IMG success and avoid conflicting or redundant processes.

c. This work should align with broader system initiatives related to equity, anti-racism, Indigenous cultural safety, physician wellness, and workplace professionalism.

4. Support retention by addressing professional and community integration.

Community integration is considered a core component of successful entry into practice for ITPs and IMGs, rather than a secondary or optional support. Evidence consistently demonstrates that professional success and physician well-being are strongly influenced by the extent to which they and their families become integrated into the communities in which they practice.

Recommendation:

a. CPSM should encourage system partners to consider how family settlement, community connection, workload, professional relationships, mentorship, and workplace culture affect whether physicians remain in Manitoba. While many of these factors are outside CPSM's direct control, they are relevant to the province's ability to retain physicians and maintain access to care, particularly in rural, northern, remote, and underserved communities.

Conclusion on recommendations:

As indicated in the introduction to this report, the above recommendations are intended to move CPSM and its system partners from problem identification to practical, coordinated action.

The evidence reviewed by the IMG Working Group, together with the focus group and survey findings, shows that successful entry into practice for IMGs and ITPs depends on more than registration eligibility alone. It requires clear regulatory information, structured orientation, effective practice-site onboarding, informed supervision and mentorship, respectful workplace cultures, safe reporting pathways, and supports that recognize the personal and community dimensions of relocation and integration.

While CPSM has a central role in setting expectations, developing regulatory resources, implementing the new Standard of Practice, and maintaining the orientation program, many of the barriers identified in this report require collaboration with health-system partners, employers, practice sites, the University of Manitoba IMG Program, Doctors Manitoba, and government. The recommendations should therefore be understood as a shared framework for improving the transition into Manitoba practice, strengthening patient safety, supporting physician wellbeing and retention, and ensuring that internationally trained physicians are welcomed, valued, and enabled to contribute fully to Manitoba's health system.

In parting, the measure of a fair and compassionate health system is not only how it assesses those who come to serve, but how it welcomes them, supports them, and makes room for their full contribution to the communities that need them.

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INTERNATIONAL MEDICAL GRADUATES

CPSM Working Group - Terms of Reference

Section 1: Background

Medical practitioners provide care to patients across the globe through the sound application of their clinical skills, knowledge, and judgment. However, health care systems in which medical education, training and care are provided, as well as other day-to-day aspects of clinical practice, vary dramatically among different jurisdictions.

CPSM has heard from registrants in the province and from other Canadian MRAs that more needs to be done to ensure new registrants with limited or no experience in the local practice environment have appropriate supports. In this regard, CPSM considers orientation, mentorship, and access to resources essential to success and the delivery of good quality care.

Initial orientation materials are currently being prepared by CPSM staff in the following areas:

- CPSM's regulatory scheme, including Standards of Practice, Practice Directions, and the Code of Ethics.
- Fundamentals of Manitoba's healthcare system and the role of the physician in that system.
- Cultural sensitivity and trauma informed practices in delivering good care.
- The patient-centered approach to care.
- Workplace culture and team-based practice environments.
- Documentation and maintenance of patient records.
- Business arrangements and practice management in non-institutional practice settings.
- Continuing professional development expectations.

CPSM staff have also taken a critical look at registration issues specific to internationally educated medical practitioners, including policies, processes, and procedures that are in place for provisionally registered physicians and the involvement of registrants in foreign recruiting practices.

The above is considered the first step in identifying and acting upon opportunities for improvement. The Registrar believes the next step calls for the establishment of a working group to reflect on the work done and make recommendations for the work to come.

Section 2: Purpose

The primary purpose of the IMG Working Group will be to assist in the development and establishment of a new orientation program. In this context, it will review current issues facing IMGs entering and maintaining practice in Manitoba.

The Working Group would also be tasked with developing and recommending a Standard of Practice for Entering the Manitoba Practice Environment. This is added as the group will be well position to do this work given the content of the orientation program.

The new Standard of Practice, which will include expectations for those already in the system and how they should receive new registrants, is planned to address orientation and respectful inter-professional relationships, workplace culture and team-based practice environments, the patient-centered approach to care, and cultural sensitivity and trauma informed practices in delivering good care.

This work is considered an important part of CPSM's Truth and Reconciliation initiatives, which is anticipated to form a significant portion of orientation.

Section 3: Roles, Functions, and Accountabilities

The following are the proposed roles, functions, and accountabilities of the IMG Working Group:

- Reporting to the Registrar:
    - Make recommendations to the Registrar on the development and establishment of an orientation program for registrants who are new to practice in Manitoba, including those who have not practiced in the Canadian health care system.
    - Review and make recommendations to the Registrar on registration issues that are specific to internationally educated medical practitioners, including policies, processes, and procedures that are in place for provisionally registered physicians.
    - Review and make recommendation to the Registrar on the adequacy of mentorship and other resources for registrants who have trained outside the country regarding acclimatizing to or synergizing with local practice environments and culture.
    - Review and make recommendations to the Registrar on issues arising from the involvement of registrants in foreign recruiting practices, including consideration as to whether CPSM has any role or responsibilities in this area and/or whether CPSM should endorse the WHO Global Code of Practice on the International Recruitment of Health Personnel.
    - Assist and make recommendations to the Registrar with respect to CPSM's obligations under subsection 8.1(1) of the *Fair Registration Practices Code*, "*to take reasonable steps to collaborate with education providers and employers to (a) identify opportunities to develop programs that may assist internationally educated individuals and unsuccessful applicants in obtaining registration …; and (b) develop programs identified …*".

- Reporting to Council:
    - Develop and recommend to Council a Standard of Practice for Entering the Manitoba Practice Environment. This would address:
        - the patient-centered approach to care,
        - cultural sensitivity and trauma informed practices in delivering good care, and
        - workplace culture and team-based practice environments.

      Note: The Standard of Practice would be circulated to registrants, stakeholders, and the public for consultation and review the results of that consultation process.
    - Finalize a Standard of Practice for Entering the Manitoba Practice Environment for approval by Council.

Section 4: Chair and Membership

4.1 Chair

The Committee will be chaired by Dr. Nader Shenouda

4.2 Membership

Working Group Membership is to include representatives from:

- CPSM Council.
- CPSM Staff.
- Registrants in active practice (particularly IMGs).
- Public representatives.
- Representatives from the Manitoba Faculty.
- Representatives from Government (MHSAL) and/or Shared Health.
- Representative from Doctors Manitoba.
- And any other representative the Chair considers appropriate.

Section 5: Meetings

Meetings will be held every month or at a frequency determined by the Working Group. Administrative support will be provided by CPSM.

Standard of Practice for Entering Practice in Manitoba

Initial Approval: June 24, 2026 **Effective Date: October 1, 2026**

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

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

This Standard outlines requirements for receiving registrants and incoming registrants who are transitioning into a new practice setting. It is intended to support patient safety and quality of care throughout the transition and to promote wellness and effective collaboration.

Please refer to the accompanying Contextual Information document for further guidance on interpreting this Standard, including definitions.

Guiding Principles from the Canadian Medical Association (CMA) Code of Ethics & Professionalism

- **Professional Excellence:** Contributing to knowledge, mentorship, teaching, system improvement.
- **Collegiality and Respect:** Cultivating respectful, collaborative relationships across the healthcare team.
- **Self-Care and Peer Support:** Fostering psychologically safe work environments and supporting colleagues in distress.
- **Physicians and Society:** Upholding system-wide efforts to improve access to equitable, culturally safe care.

Part 1: Building relationships when entering a new practice setting

All registrants are expected to:

- Ensure a shared understanding of roles and responsibilities in the practice setting, including each health professional's scope of practice, limits, and accountabilities in delivering patient care.
- Foster mentorship, team collaboration and shared accountability for patient care, recognizing that these are essential to safe patient care and professional growth.

- Promote a culture that is open and receptive to feedback, recognizing it is crucial that all registrants can speak up, seek help, and share concerns and advice with one another.

Receiving registrants are expected to:

- Support new colleagues by contributing to orientation, mentorship, and professional development activities that promote safe and competent practice.
- Be approachable and responsive and encourage registrants new to the practice setting to ask questions or request assistance.
- Only assign or expect colleagues to provide care or medical services that they are safe and competent to provide.
- Actively participate in maintaining the standards of the profession by ensuring that expectations are clearly communicated and modeled in practice.

Registrants entering a new practice must:

- Actively engage in orientation.
- Openly communicate with colleagues about training, experience, and any areas where extra support is needed.
- Work within limits and ask for help whenever unsure or facing a situation beyond the registrant's competence or privileges.
- Adapt practices to meet local standards as appropriate.

Part 2: Orientation is key to a safe landing in practice

Orientation to the practice setting is required:

- Formal leaders in practice settings who are CPSM registrants are expected to undertake reasonable measures within their control and authority to ensure that structured onboarding and orientation programs are provided for registrants new to the practice setting. Orientation and onboarding should be appropriate to the setting and the incoming registrant.

Orientation content:

- While appropriate domains of orientation will vary based on context, orientation should address:
    - **Patient-centred care and cultural competence.** This includes orientation about the local patient population and local culture, including Indigenous health needs, rural populations, and patient expectations.
    - **Preventing anti-Indigenous racism.** This includes understanding the systemic racism experienced by Indigenous people and the concerted efforts required to create awareness and take meaningful steps to prevent anti-Indigenous racism. Registrants should be supported in meeting CPSM's mandatory cultural and anti-Indigenous training requirements.
    - **Workplace culture and team-based practice.** Registrants new to the practice setting may come from a system where things were done differently; so,

adapting to a new reality may involve a learning curve. Orientation should consider that differences in collaborative care requirements often exist between practice settings and jurisdictions.
    - **Communication.** Orientation should include topics of communication that emphasize local dialect, medical colloquialisms, and patient-centred dialogue.
    - **Practice administration.** Differences in administrative aspects of practice should be addressed, for example, systems for maintaining patient records and billing.

Part 3: Commitment to self-care and peer support.

Registrant health and wellness:

- Registrant health and wellness is a shared responsibility that extends beyond the individual. Inclusion, cultural humility, and creating a psychologically safe space that supports wellness are important in practice, particularly during a stressful period of transition into a new practice setting, environment, or community.
- In supporting registrants new to a practice setting, receiving registrants should model the commitment to self-care and peer support by respecting limits, encouraging healthy boundaries, and acknowledging – as applicable - the unique stressors that may accompany relocation, cultural adaptation, and entering a new practice.

As part of their professional obligations, all registrants are expected to:

- Demonstrate a commitment to personal health and wellness, recognizing that self-care and balance between personal and professional responsibilities are essential to sustainable practice.
- Value and promote a practice environment where all colleagues feel empowered to seek help and access support related to physical, mental, and social well-being.
- Encourage open dialogue, recognize signs of distress or burnout, normalize help-seeking behaviours, and engage with empathy and discretion when a colleague may be struggling.

Part 4: Workplace culture and professionalism

Commitment to professional excellence:

- A professional and collaborative workplace culture is crucial to maintaining ethical standards in practice. This enables registrants to uphold core values such as respect, integrity, collaboration, and accountability, fostering trust among colleagues and patients, and supporting the delivery of safe, quality care.
- Receiving registrants play a vital role in fostering a safe, inclusive, and supportive practice environment for registrants entering a new practice setting. Recognizing systemic biases that exist in the medical profession, receiving registrants should promote inclusivity and belonging. This includes involving new registrants in decision-making processes and leadership roles to foster a sense of professional integration.

All registrants must:

- Treat colleagues respectfully, with dignity, and show cultural humility in interactions.
- Call out all forms of hostility and discrimination when observed in practice and take meaningful steps to address discriminatory acts and omissions.
- Support colleagues who experience harassment or discrimination from any source.

Related Standards of Practice:

- *Collaborative Care*
- *Non-Emergent Consultation Requests*
- *Emergent, Urgent and Inpatient Requests*
- *Practicing Medicine to Eliminate Anti-Indigenous Racism*

Related Resource:

- *Contextual Information – Entering a New Practice Setting*.

Contextual Information and Resources for the Standard of Practice for Entering Practice in Manitoba

Initial Approval: June 24, 2026 **Effective Date: October 1, 2026**

Contextual Information and Resources are provided to support registrants in implementing the Standard of Practice. Contextual Information and Resources do not define the Standard of Practice, nor should this be interpreted as legal advice. It is not compulsory, unlike a Standard of Practice. Contextual Information and Resources are dynamic and may be edited or updated for clarity, new developments, or new resources at any time.

Purpose and context for the Standard

Entering a new practice environment—whether as a newly licensed physician trained in Canada, an internationally trained physician on internation medical graduate (ITP/IMG), or a registrant transitioning between practice settings—creates significant shifts in clinical, cultural, administrative, and relational expectations. The Standard is intended to support safe integration, uphold patient safety, and foster professional success for both the new registrant and those already established in the practice setting.

The Standard is grounded in the recognition that new registrants often arrive with diverse training backgrounds and clinical strengths, but may have limited experience with the Manitoba or Canadian healthcare context, including differences in:

- systems of care,
- community expectations,
- documentation practices,
- communication norms,
- collaborative care models, and
- professional and cultural expectations.

Because of these differences, structured orientation and onboarding, mentorship, and supportive workplace culture are critical components of safe and effective integration.

Relationship to the Canadian Medical Association (CMA) Code of Ethics and Professionalism

The Standard is not a standalone document—it must be read in conjunction with the **CMA Code of Ethics and Professionalism**, which informs nearly every expectation. Key ethical commitments relevant to entering a new practice setting include:

- Professional Excellence: contributing to knowledge, mentorship, teaching, system improvement.
- Collegiality and Respect: cultivating respectful, collaborative relationships across the healthcare team.
- Self-Care and Peer Support: fostering psychologically safe work environments and supporting colleagues in distress.
- Physicians and Society: upholding system-wide efforts to improve access to equitable, culturally safe care.

Interpreting the Standard

- **Registrants and formal leaders –** The term **registrants** used in the Standard refers to people registered with CPSM, including physicians, surgeons, clinical and physician assistants, and educational registrants. A registrant who, in addition to providing clinical services, holds a defined role of authority or responsibility for the governance, oversight, quality, or supervision of clinical practice within a practice environment (e.g., clinic, facility, or departmental or program setting) would be considered a formal leader. This would include a physician who is appointed as the Medical Director.

- **Community of practice -** Means the collective professional environment in which registrants work together to deliver patient care. It includes formal structures (such as teams, clinics, and organizations) and informal professional relationships, and is characterized by shared accountability for patient safety, professional standards, learning, and mutual respect.

- **Cultural humility -** Is understood as an ongoing commitment to self-reflection, openness to learning, and recognition of the limits of one's own knowledge and experience. It includes respect for diverse cultural, educational, and professional backgrounds, and an awareness of systemic inequities that may affect colleagues and patients.

- **Inclusive professionalism -** Refers to professional behaviours that foster belonging, equity, and respect within the medical profession. This includes valuing diverse training pathways, addressing bias or discrimination, supporting psychological safety, and ensuring that all registrants can participate meaningfully in professional and clinical decision-making.

- **Shared responsibility -** Reflects the principle that successful integration into a new practice setting depends on both individual accountability and collective professional support. Registrants are expected to contribute, within their roles and influence, to environments that support learning, wellness, ethical practice, and continuous improvement.

Why orientation and onboarding are required

Information and data from surveys, focus groups, and the literature collected by CPSM consistently show that the lack of structured orientation contributes to:

- patient safety risks,
- misunderstandings about roles and responsibilities,
- delayed integration into team-based practice,
- difficulty navigating local administrative processes, and
- feelings of isolation, stigma, or exclusion among new registrants.

Orientation must therefore be structured, proportionate to the setting and role, and tailored to the individual's background and experience.

Key domains orientation should address include:

- patient-centred care and cultural competence,
- cultural safety and preventing anti-Indigenous racism,
- local patient population and community context,
- workplace culture and team-based practice expectations,
- communication norms, including colloquialisms and local dialect,
- EMR usage, documentation, billing, administrative workflows, and
- understanding roles, limits of practice, and supervisory requirements.

Professional culture and expectations

Surveys of Manitoba registrants reveal that new physicians frequently encounter challenges such as:

- unclear role expectations,
- lack of mentorship and feedback,
- variability in team-based care norms,
- differing expectations around patient load, workflow, and interprofessional communication,
- cultural misunderstandings, and
- difficulty accessing peer support.

These findings reinforce why the Standard emphasizes:

- building collaborative and respectful relationships,
- promoting a culture of constructive feedback and open communication,
- clarifying scopes of practice and responsibilities, and
- addressing discriminatory or exclusionary behaviours.

Receiving registrants have a duty to model professionalism and collegiality, including because new registrants often observe and absorb workplace culture through their interactions.

Cultural safety and equity

Evidence from surveys and working group consultations demonstrate that IMGs/ITPs frequently report:

- assumptions being made about their competence,
- exclusion from decision-making,
- a sense of conditional belonging when under provisional licenses, and
- exposure to bias or systemic inequities.

The Standard therefore calls for:

- cultural humility,
- inclusive decision-making,
- confronting incivility and discrimination,
- recognizing the impact of systemic bias, and
- integrating Indigenous-specific cultural safety principles into orientation.

Physician wellness and psychological safety

Transitions into new environments are periods of heightened stress. The Standard emphasizes the shared responsibility of:

- modelling healthy boundaries,
- recognizing signs of distress or burnout,
- supporting colleagues in need, and
- creating psychological safety for help-seeking.

How the Standard supports system-level goals

The Standard aligns with system-wide objectives identified by CPSM's IMG Working Group, including:

- improving equitable access to care,
- strengthening retention,
- enhancing collaborative care,
- supporting the integration of internationally trained professionals,
- advancing reconciliation by addressing anti-Indigenous racism in care, and
- promoting high-quality care across diverse settings.

Behaviours demonstrating a registrant is meeting this Standard

Shared responsibility and community of practice

- Proactively welcoming a colleague who is new to the practice setting and ensuring they are introduced to team members, workflows, and informal norms of the workplace.
- Recognizing that supporting colleagues entering practice is a collective professional responsibility, not limited to formal supervisors or leaders.

- Participating constructively in team discussions that address integration, workload distribution, and patient safety during periods of transition.

Communication and role clarity

- Taking reasonable steps to communicate clearly about one's own scope of practice, training background, and limits, particularly when joining a new clinical team.
- Ensuring that roles and responsibilities within team-based care are discussed and understood, especially when working with colleagues from different jurisdictions or practice models.
- Seeking clarification when unfamiliar terminology, systems, or expectations arise, rather than making assumptions that could affect patient care.

Orientation, onboarding, and mentorship

- Participating in developing and maintaining structured orientation or onboarding processes that address local clinical expectations, administrative systems, and community context.
- Supporting or contributing to mentorship, supervision, or peer-support arrangements that help new registrants integrate safely and effectively.
- Recognizing that orientation may be ongoing and engaging in continued learning about Manitoba's health system, local patient populations, and professional norms.

Cultural humility and inclusive professionalism

- Demonstrating openness to learning from colleagues with different training pathways, cultural backgrounds, or professional experiences.
- Reflecting on one's own assumptions or biases and taking steps to ensure they do not affect collegial interactions or professional decision-making.
- Engaging colleagues entering practice in meaningful clinical, professional, or organizational discussions, rather than excluding them from decision-making processes.
- Many ITPs report experiencing professional bias or assumptions about their training or competence, which can often result in exclusion. They also report a sense of conditional belonging or lack of autonomy when under provisional licenses, which can affect morale. Following the above examples can mitigate this issue.

Respectful and psychologically safe practice environments

- Treating colleagues with dignity and respect, and addressing incivility or discriminatory behaviour when it arises, consistent with professional obligations.
- Fostering an environment in which colleagues feel safe to ask questions, raise concerns, or seek guidance without fear of reprisal or stigma.
- Responding to feedback—whether given or received—with openness, professionalism, and a commitment to learning.

Self-care and peer support

- Modelling healthy professional boundaries and acknowledging the personal and professional stressors that accompany relocation or transition into a new practice setting.

- Encouraging colleagues to access available wellness, peer support, or professional resources when needed.
- Responding with empathy and discretion when a colleague appears to be experiencing distress or burnout, while recognizing shared responsibility for physician wellness.

Commitment to patient safety and quality of care

- Adjusting practice behaviours, supervision, or consultation patterns as needed during periods of transition to ensure patient safety is maintained.
- Participating in quality improvement, mentorship, or educational activities that support competence and confidence in new practice environments.
- Recognizing that safe integration of new registrants contributes to broader system sustainability and access to care.

Frequently asked questions

Q: As an ITP new to practice in Manitoba, I am sometimes unsure about local protocols or when to call for help. How should I handle this?

A: Always ask for help when you need it. Seeking guidance is a sign of responsibility. The Standard expects new registrants to recognize their limits and speak up, especially when patient care could be affected. If you're unsure about a local procedure (for example, how to arrange an urgent referral or use a specific electronic tool) or you're facing a case beyond your comfort level, proactively reach out to a colleague. It's often best to ask early rather than struggle in silence – a quick question can prevent errors. To make this easier, many practices designate a mentor or "*go-to*" person; take advantage of that support. Also, prepare by learning the local protocols from orientation materials, but understand that it's normal to have questions even after reading them. Importantly, don't let fear of looking inexperienced stop you from voicing concerns. Your colleagues expect some questions and would much prefer you to ask them rather than make a harmful mistake. Over time, as you become familiar with the environment, you'll need less assistance. But even experienced registrants consult each other when in doubt – that's part of maintaining high-quality care.

Q. What if a new registrant's approach to care is different from our usual practices?

A. It's common for new colleagues to have different approaches, given their diverse training backgrounds. Safety and quality come first. If the new colleague's approach is clinically sound but just different, be open to it. Many variations (for example, a different medication choice that achieves the same result) can be accommodated in practice. In fact, you might learn something new or find a better way. However, if the approach conflicts with established local protocols or could pose a risk (perhaps due to resource differences or patient expectations), you should discuss it openly. Explain the local standard and the rationale behind it (e.g., "*We do it this way here because our labs process tests differently*" or "*Our patients are used to this care pathway*"). The new colleague should adapt to meeting local standards, but the adaptation period is a two-way learning opportunity. Both parties should practice cultural humility. Avoid

dismissing something as "*wrong*" just because it's unfamiliar. Instead, evaluate whether it meets the patient's needs and fits the local context. Often, a hybrid approach or a small adjustment can incorporate the new idea without compromising care. The key is open communication. Ensure the new registrant feels comfortable explaining their perspective, and likewise they should respect guidance from experienced colleagues. Over time, practice styles will harmonize as the new colleague gains understanding of local expectations and the team values the strengths of their new colleague.

Q. How should I address disrespectful or biased behavior toward the new ITP in our team?

A. A respectful, inclusive workplace is essential. If you observe a colleague or staff member treating any team member in a disparaging or biased manner, it's important to act:

- **Address it early (if safe).** If someone makes an inappropriate remark about a colleague's background or abilities, speak up in a professional way. For example, a gentle correction like, "*We don't judge skills by where someone trained; Dr. X is a valued member of our team,*" can set the tone.
- **Support colleagues.** Check in with your colleague privately afterward. Acknowledge what happened, reassure them of their value, and encourage them to report any future incidents. Knowing they have allies can make a big difference.
- **Document and report if needed.** If disrespect or harassment continues, document specific incidents (dates, what was said or done). Escalate as appropriate. CPSM can also provide guidance if the issue involves professional conduct. Remember that the standard – and the Code of Ethics – require confronting incivility and protecting colleagues from unfair treatment.
- **Model inclusive behavior.** Ensure you consistently treat the new registrant as an equal colleague. Involve them in discussions, introduce them to others, and give them credit for their contributions. Often, setting a strong positive example will discourage others from acting negatively.
-

No one should be made to feel like a "*second-class*" team member. Disrespectful behaviour not only harms the registrant, but it can also affect patient care by undermining team cohesion. By addressing issues promptly and decisively, you help create a culture where everyone can perform at their best.

Q. I'm new to practice and I feel overwhelmed by the workload and new environment. What should I do?

A. Feeling overwhelmed is not unusual during a big transition. The key is to recognize it and respond early:

- **Speak up.** Let colleagues know that you're struggling with the workload or certain tasks. This isn't complaining, rather it is about patient safety and your well-being. Together,

you can find solutions, such as adjusting your schedule, getting more support for certain duties, or clarifying priorities.

- **Use available resources:** Tap into support systems. Many institutions have registrant wellness programs, mentorship groups, or even informal networks. Connecting with peers who have gone through similar transitions can provide practical tips and moral support. CPSM and other organizations can also direct you to resources for stress management or counseling if needed.

- **Set boundaries and self-care:** While you may be eager to prove yourself, remember that medicine is a team sport. Take breaks, ensure you're eating and resting, and don't hesitate to say "no" to additional non-mandatory responsibilities until you've found your footing. It's better to do a solid job with a slightly reduced load than to risk burnout by taking on too much.

- **Remember it gets better:** Almost every registrant has felt the steep learning curve of a new position. With each week, you will become more efficient and more comfortable in the system. If you've communicated openly and sought help, you'll find that colleagues will rally to assist you. Over time, as you gain confidence, the sense of overwhelm should lessen. However, if you continue to feel overburdened despite these steps, consider reaching out to CPSM or a professional support service for guidance – sometimes there may be systemic issues that need addressing in your practice setting.

Resource guide

[Under development]

COUNCIL MEETING
SEPTEMBER 23, 2026
NOTICE OF MOTION FOR APPROVAL BRIEFING NOTE

SUBJECT: Accredited Facilities Bylaw Revisions - Consultation

BACKGROUND:

At the June 24, 2026 meeting, Council approved proposed amendments to the *Accredited Facilities Bylaw* (See ***Appendix A***) be posted for 30 days for consultation with registrants and interested stakeholders, and that the proposed amendments be provided to the Minister for their review and comment.

The amendments included changes to:

- Definition of "diagnostic imaging facility" to include echocardiography.
- Definition of "oral sedation" for Non-Hospital Medical or Surgical Facilities.
- Definition of "procedural sedation" for Non-Hospital Medical or Surgical Facilities.
- Procedures requiring accreditation – diagnostic cystoscopies using disposable equipment.
- Procedures requiring accreditation – ketamine administration.
- Procedures requiring accreditation – Sleep Medicine Diagnostics.
- Clarifying a responsible adult is required for discharge from Non-Hospital Medical or Surgical Facilities.
- Reporting adverse patient outcomes.

Consultation began July 27, 2026 with deadline for feedback on August 27, 2026.

Attached as ***Appendix B*** are the 17 consultation responses received. 7 are from Registrants, 7 from the public and 3 from stakeholders. No response was received from the Minister.

The responses are directed to the following amendments:

- 1 comment on the definition of "oral sedation"
- 8 comments on ketamine administration (5 individuals submitted the same comment)
- 5 comments on responsible adult
- 3 comments on more than 1 topic of amendments

The Executive Committee requested the Program Review Committee to provide its feedback on the consultation responses relating to the ketamine administration. Accordingly, the bylaw amendment related to ketamine administration has been removed from this agenda item and will be returned to the December 9, 2026 Council meeting for consideration.

Appendix C – is the proposed amendment to The Accredited Facilities Bylaw. These amendments are the ones consulted on less the amendments related to ketamine

administration and diagnostic cystoscopy. The recommendation is to adopt these proposed amendments as drafted for consultation.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

> The proposed amendments to the Accredited Facilities Bylaw be approved as presented in Appendix C.

Notice of Motion for Approval Briefing Note Prepared by: Mr. Mike Triggs, General Counsel

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Accredited Facilities Bylaw

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

The College of Physicians and Surgeons of Manitoba

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

Effective Date January 1, 2019
With revisions up to and including June 25, 2025

Table of Contents

Preamble

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

PART A – DIAGNOSTIC FACILITIES

Article 1 – Definitions

1.1. In Part A of Bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 2 – Application of this Part

Part A of this Bylaw applies as follows:

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

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than

(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;

(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and

(c) a facility or class of facility exempted by regulation from the application of this section.

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

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

Article 3 – Facility Accreditation

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

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

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

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

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

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

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

Accreditation Process

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

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

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

Full Accreditation

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

Accreditation Not Granted

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

Conditional Accreditation

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

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

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

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

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

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

Accreditation Status Review

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

Temporary Accreditation

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

Role of Facility Director During Accreditation

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

Article 4 – Maintenance of Accreditation

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

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

Article 5 – Renewal of Accreditation

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

Article 6 – Variance or Withdrawal of Accreditation

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

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

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

6.4 Council may withdraw accreditation in accordance with the RHPA

Article 7 – Facility Director

7.1. A facility must have a Facility Director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.8.15.i. equipment.

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

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

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

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

Article 8 – Appeal

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

Article 9 – Fees

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

Article 10 – Physician Office Laboratory

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

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

Article 11 – Transition

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

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

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

PART B – NON-HOSPITAL MEDICAL OR SURGICAL FACILITIES

Article 12 – Definitions

12.1. In Part B of this Bylaw:

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

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

"Committee" means the Program Review Committee of CPSM.

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

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

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

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

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

"~~-~~procedural **oral sedation**" means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents given orally before a procedure under supervision and ~~with~~ which may be ~~is~~ accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient ~~can~~ is likely to be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states. Procedural oral sedation should have the same credentialing or monitoring purposes as for procedural sedation.

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

“procedural sedation” means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

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

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

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

Article 13 – Application of this Part – Procedures Requiring Accreditation

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

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

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

13.3.3.i.a. resection of a deep, major or complicated lesion;
13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;

13.3.3.ii. flexible endoscopic evaluation of: ~~the gastrointestinal or genitourinary tract;~~
13.3.3.ii.a the gastrointestinal tract
~~13.3.3.ii.~~ 13.3.3.ii.b the genitourinary tract- this does not include diagnostic cystoscopy using disposable equipment
13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;
13.3.3.iv. the following Ophthalmological Procedures:
13.3.3.iv.a. cataract surgical procedures
13.3.3.iv.b. corneal laser procedures
13.3.3.iv.c. retinal procedures limited to scleral buckling and vitrectomies
13.3.3.iv.d. Lasik therapeutic procedures
13.3.3.v. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;
13.3.3.vi. liposuction procedures;
13.3.3.vii. hair transplantation;
13.3.3.viii. venous sclerotherapy;
13.3.3.ix. hyperbaric oxygen therapy;
13.3.3.x. hemodialysis;
13.3.3.xi. ~~intravenous~~ Ketamine administration: ~~—~~any route and in any formulation including commercially available products as well as any compounded formulations;
13.3.3.xi.a. excluding topical preparations including creams, ointments, etc.
~~13.3.3.xi.~~13.3.3.xi.b. excluding ketamine administered in the context of palliative care
13.3.3.xii. MDMA (3,4-methylenedioxymethamphetamine); ~~or~~
~~13.3.3.xii.~~13.3.3.xiii. ~~Sleep Clinics~~ Sleep Medicine

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

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

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

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

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

Article 15 – Facility Accreditation

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

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

Accreditation Process

15.3 The accreditation process will include:

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

15.4 On completion of the accreditation process, the Committee may:

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

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

Full Accreditation

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

Accreditation Not Granted

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

Conditional Accreditation

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

15.9 Where conditional accreditation is granted, the Committee must:

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

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

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

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

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

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

15.12.1 extend conditional accreditation;

15.12.2 direct an inspection;

15.12.3 withdraw the conditional accreditations.

Temporary Accreditation

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

Term of Accreditation and Renewal

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

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

Article 16 – Maintenance of Accreditation

16.1 In order to maintain accreditation, a facility must:
- 16.1.1 comply with the relevant requirements;
- 16.1.2 perform only the procedures permitted pursuant to the facility's certificate of accreditation;
- 16.1.3 at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect; and
- 16.1.4 cooperate with and participate in the inspection process approved by the Committee for its type of facility.

16.2 During the currency of a full or conditional accreditation the Committee may direct an inspection for the purpose of monitoring compliance, if the Committee is of the opinion that:
- 16.2.1 a facility may not meet the requirements, standards of practice, or other standards for public safety and.
- 16.2.2 an inspection would be in the public's best interest.

Article 17 – Renewal of Accreditation

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

Article 18 – Variance or Withdrawal of Accreditation

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

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

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

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

Article 19 – Approved Procedures

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

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

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

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

Article 20 – Health Authority Agreement

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

Article 21 – Privileges

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

21.2. The Medical Director must only grant and renew privileges for a registrant to perform procedures in an accredited facility if the Medical Director is satisfied that:
- 21.2.1. the applicant is a suitable and competent candidate
- 21.2.2. the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant and
- 21.2.3. those privileges are the same as granted by Shared Health or a Regional Health Authority or are recommended through the Shared Health credentialing process and those privileges are and remain in good standing.

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

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

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

Article 22 – Standard of Care

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

22.1.3. engage in ongoing processes of self-review and quality improvement.

Article 23 – Patient Care

23.1. Anaesthetic Care

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

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

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

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

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

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

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

23.2. A registrant who has been granted privileges must:

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

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

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

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

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

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

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

Article 24 – Infection Control

24.1 A facility must:

24.1.1 use sterilization techniques,

24.1.2 store medical and dental supplies, and

24.1.3 use waste handling and disposal procedures

consistent with the standards applicable to hospitals.

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

Article 25 – Medical Director

25.1 The facility shall appoint a medical director, who is a registrant acceptable to the Committee, and who must:

25.1.1 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

25.1.2 be responsible for the administration of the facility; and

25.1.3 provide required reporting to CPSM.

25.2 In enforcing the standards of care in the facility which includes the safe and effective care of patients, the medical director must ensure that:

25.2.1 procedures and equipment are appropriate and safe;

25.2.2 procedures are performed in accordance with current good medical care and practice;

25.2.3 sufficient numbers of appropriately trained personnel are present during procedures;

25.2.4 procedures approved by the Committee as set out in the certificate of accreditation are only performed at the facility by registrants with privileges;

25.2.5 persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;

25.2.6 registrants with privileges have current basic life support skills and other skills appropriate to the clinical settings (such as advanced cardiac support, pediatric advanced life support, and airway management skills);

25.2.7 all direct patient care personnel have life support skills and there must be two such qualified personnel present at any time patients are receiving care;

25.2.8 adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place.

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

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

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

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

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

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

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

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

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

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

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

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

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

25.4.1.iii unexpected admission to hospital and/or presenting to an Emergency Department or Urgent Care within 10 days of a procedure performed;

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

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

25.4.1.vi any other major adverse patient outcome.

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

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

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

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

Article 26 – Audit and Quality Control

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

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

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

Article 27 – Annual Report

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

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

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

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

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

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

27.2.5 the number of transfers to hospital from the facility

27.2.6 list of registrants with privileges and health care staff

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

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

Article 28 – Inspections and Audits

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

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

28.1.2. renovations in the facility;

28.1.3. an adverse patient outcome;

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

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

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

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

Article 29 – Appeal

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

Article 30 – Administration Fees for Facilities

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

Article 31 – Transition

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

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

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

NOTE – The list for additional procedures for section 13.3 is on the next page.

REGISTRANT FEEDBACK	
Name	**Comment**
[redacted]	Hello, I was recently reviewing your most recent update and was hoping to get a little more clarification on point 7. 7. Clarifying a responsible adult is required for discharge from Non-Hospital Medical or Surgical Facilities. Currently, a patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of an adult. This is amended to clarify it should be a responsible adult. 23.1.3 A patient who receives general anaesthesia or procedural sedation should only leave the facility in the care of a responsible adult. I am a co-medical director at [redacted] where we provide general anesthesia [redacted] and have over the years encountered unfortunate scenarios wherein a parent has left while their child was under general anesthesia and has returned inebriated under the influence of alcohol. In these cases we have called CFS, and thankfully they have been able to attend quickly to the situation and offer assistance with regards to arranging care for the child. However we have been informed that we do not technically have any right to withhold the child from the parent and we are not legally able to prevent them from leaving the premises. We were instructed that if the parent were to leave with the child forcefully prior to CFS being able to attend that we should contact the police. We have also contacted CMPA who essentially confirmed the above. To be honest this idea did not seem satisfactory to us. Thankfully in our situations we were able to coax the inebriated parents into staying until CFS arrived. I am specifically wondering if this new update changes this circumstances and allows us the regulatory framework to not discharge a patient into the care of an inebriated care provider. Would we legally have backing in refusing to discharge and withholding a child in the above situations based on this? If its easier to discuss via telephone I can be reached at [redacted]
[redacted]	Hello,

	With respect to the changes of 'procedural oral sedation' - I am wondering if there are possible exclusions that may be met. For example, a patient may take an ativan prior to a flight as prescribed by a physician. If, however, this same person takes an ativan prior to a nurse-directed/nurse performed esthetic procedure with a nurse (i.e. member of a regulated profession) present, this can only be done in an accredited facility with two registrants with knowledge of ACLS etc.? I understand the appropriate need of the CPSM to protect the public and put safeguards in place, however this seems like overreach that will create unnecessary barriers in helping people manage aesthetic concerns comfortably, particularly given the standards that nurses are held to in every other facility. I believe that nurse directed care under the observation (remote - as with PCH - or otherwise) of a physician should be sufficient with respect to a minimal amount of 'oral procedural sedation'. Or one could consider the term 'oral procedural sedation' to be much too broad - am I sedating every patient for whom I prescribe a benzodiazepine or is it only in the context of a procedure that it requires additional bureaucratic resources to be tied up? I appreciate the CPSM and their interest in updating their policies, however in this case this brush is a little too wide. Thank you for the opportunity to weigh in. Regards, [redacted]
[redacted]	I am writing to comment on the proposed changes in he Accredited Facilities Bylaw below. Many patients requiring outpatient gastrointestinal endoscopy do not have family members or friends willing or able to accompany them for their gastroscopy or colonoscopy. In the past, hospital nurses have interpreted the "responsible adult" requirement to not include licensed Taxi or Uber drivers, thereby preventing these patients from receiving conscious sedation for their procedures. To my knowledge, over the past few years we have not had any major problems at St. Boniface or Victoria hospital allowing patients who are fully recovered to leave by taxi after being accompanied to the front door of the facility by hospital staff or volunteers. I am afraid that by adding the word "responsible" adult, confusion will again arise for patients with no available family member or friends. They will either be denied access to the procedure or will suffer pain by being considered ineligible for procedural sedation because of the proposed bylaw amendment. I would favor leaving the bylaw as it is or adding that a licensed driver is considered a responsible adult to avoid this discriminatory situation. [redacted]

[redacted]	This is correct. The [redacted] conscious sedation documents were clear (after review with [redacted] legal) that it was a "SHOULD" be discharged in the company of a responsible adult, not a "MUST", as it was felt SHOULD would be more fair and equitable for unhoused, widowed, and solitary folks who do not have family available.
[redacted]	To whom this concerns, My one thought about the amendments is for amendment 23.1.3 regarding a "responsible" adult. Perhaps this is written with clarity elsewhere, but I'm not sure what "responsible" means and could leave room for a lot of interpretation.
[redacted]	To Whom It May Concern, I am writing in response to the proposed amendments to the Accredited Facilities Bylaw currently open for public consultation. As a physician working with patients affected by mental illness, addictions, and trauma, I see firsthand the significant impact that treatment-resistant depression, anxiety disorders, PTSD, and other mental health conditions can have on people's lives. Despite receiving appropriate care, many individuals continue to struggle and are left with few effective treatment options. Ketamine-assisted therapy, and potentially other forms of psychedelic-assisted therapy as they emerge, represent promising evidence-informed approaches for people who have not benefited from conventional treatments. Manitobans deserve safe and reasonable access to these therapies when clinically appropriate. While I fully support the need for strong patient safety standards, I am concerned that regulating these therapies under the same framework as surgical and anesthetic procedures may not reflect the realities of how they are typically delivered. In most cases, ketamine-assisted therapy involves carefully selected patients, relatively low medication doses, continuous monitoring, and support from trained healthcare professionals in a therapeutic environment. This model differs significantly from procedural sedation or surgical anesthesia. My concern is that applying standards designed for operating rooms and surgical facilities could create unnecessary barriers to access without providing meaningful additional safety benefits. At a time when we are facing increasing mental health needs across Manitoba, it is important that regulatory frameworks balance patient safety with reasonable access to innovative and potentially life-changing treatments. I encourage the College to consider developing a distinct accreditation pathway or standards specific to ketamine-assisted therapy and future psychedelic-assisted therapies. Such an approach could maintain appropriate safeguards while ensuring that patients are not denied access to emerging treatments that may offer significant benefit when other options have failed.

	Thank you for considering this feedback and for your commitment to protecting the public while supporting the evolution of evidence-based mental health care in Manitoba. [redacted]
[redacted]	**LETTER 1**

PUBLIC MEMBER FEEDBACK

Name	Comment
[redacted]	To Whom It May Concern, I have reviewed the proposed amendments and within my scope as a [redacted], have no concerns and agree.
[redacted] *This comment was submitted by five different individuals.	To Whom It May Concern, I am writing about the proposed Amendments to the Accredited Facilities Bylaw, open for public consultation until August 27, 2026. Many Manitobans living with depression, anxiety, and other mental health challenges have not found relief through currently available treatments. Ketamine-assisted and psychedelic-assisted therapies offer real promise for people in this situation, and Manitobans deserve the opportunity to access these options as they become available. As I understand it, the proposed amendments would regulate this type of therapy under the same rules used for surgical and anesthetic procedures. In practice, however, the therapy typically involves a low dose of medication, guidance from a trained therapist, and several hours in a supportive setting. Treating it like surgical sedation will make access more difficult without improving safety. I'd ask the College to consider a separate set of rules built specifically for ketamine-assisted therapy and other psychedelic assisted therapies that keep patients safe without shutting the door on treatments that could genuinely help people who are struggling. Thank you for considering this feedback.

[redacted]

On review of the proposed bylaw changes noted below, I want to state my plea that changes be made with thorough consideration for patient access to care.

While of course the CPSM must protect the public from potential harms that can arise from a patient accessing care inappropriately provided - I believe CPSM must also protect the public from the harms of superficial barriers to care, especially when that care might potentially be of benefit to a highly marginalized patient group (those experiencing severe mental illness).

While I do not practice in the area of psychedelic-assisted therapies, it is an evolving field in mental health care that I think deserves close attention. I hope that CPSM is being mindful of the growing evidence around psychedelic and ketamine-assisted psychotherapies, and is not creating undue hardship for patients to access this care in the future (as the evidence evolves) through these bylaw updates.

I also hope CPSM is not prioritizing or consolidating physician power over patients' access to care in these or any changes, and is understanding of the roles other providers in various settings can play in improving patient mental health in Manitoba.

2. Definition of "oral sedation" for Non-Hospital Medical or Surgical Facilities. The definition is amended to clarify that it applies to procedural oral sedation given before a procedure.	Section 12.1 - "procedural **oral sedation**" means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents given orally before a procedure under supervision and with which may be accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can is likely to be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states. Procedural oral sedation should have the same credentialing or monitoring purposes as for procedural sedation.

5. Procedures requiring accreditation – ketamine administration. The amendment will require that ketamine administered outside of a hospital can only be administered in accordance with the Accredited Facilities Bylaw. However, ketamine administered in the context of palliative care or topical preparations (creams and ointments) is excluded from this requirement.	Section 13.3.3.xi intravenous Ketamine administration any route and in any formulation including commercially available products as well as any compounded formulations; 13.3.3.i.a. excluding topical preparations including creams, ointments, etc. 13.3.3.i.b. excluding ketamine administered in the context of palliative care.

	[redacted]
[redacted]	To Whom It May Concern, I am writing about the proposed Amendments to the Accredited Facilities Bylaw, open for public consultation until August 27, 2026. Many Manitobans are living with depression, anxiety, and other mental health challenges and my observation is that these challenges continue to grow in our Province. I understand ketamine-assisted and psychedelic-assisted therapies have, in other jurisdictions, helped people in these situations. Because ketamine-assisted and psychedelic-assisted therapies typically involve a low dose of medication couple with trained therapist guidance in a controlled and supportive setting, I would encourage the College to consider developing a unique, purpose-built regulatory regime for them versus treating the therapies like surgical sedation from a regulatory perspective. In designing a Made-in Manitoba regulatory framework with the goal of having as many Manitobans as feasible obtain care in safe settings, the potential exists to improve many Manitobans' overall health and, simultaneously, reduce the current burden faced by both our community crisis responders and our in-hospital healthcare systems. Thank you for considering this input. Sincerely, [redacted] [redacted]
[redacted]	Good morning, Thank you for the opportunity to provide feedback on the proposed amendments to the Accredited Facilities Bylaw and The Affairs of the College Bylaw. Please see my feedback below.

[redacted]	**7. Clarifying a responsible adult is required for discharge from Non-Hospital Medical or Surgical Facilities.** - The amendment changes the wording to a "responsible" adult, which I absolutely agree with. However, this change creates more room for interpretation, which requires some supportive clarification for providers and patience. What constitutes a responsible adult? Are there criteria being formed? How is a responsible adult being assessed? Who is it being assessed by? Thank you for your time and consideration, [redacted]
[redacted]	**LETTER 2**
[redacted]	**LETTER 3**

[redacted]	
STAKEHOLDER FEEDBACK	
Name	**Comment**
Deb Elias, Registrar & CEO, The College of Registered Nurses of Manitoba (CRNM)	**LETTER 4**
Marie-Ly Poirier Paralegal, Collège des médecins du Québec	Hello, Thank you for the opportunity to comment the proposed amendments to the Accredited Facilities Bylaw. Although the Collège des médecins du Québec does not exercise an accreditation function comparable to that of the CPSM, we note that many of the requirements and safeguards contemplated by the proposed amendments are broadly consistent with the mechanisms used in Québec to support quality and patient safety. In some cases, these expectations are established through legislation governing specific laboratory activities, while in others they are reflected in professional or interprofessional guidelines where no legislative or regulatory framework exists. **Marie-Ly Poirier** Paralegal Legal Affairs Directorate **Tel.** 514-933-4441, ext. 5304 | 1-888 PHYSICIAN **Fax:** 514-933-3276
Chantelle Dick, Manager, Standards of Practice, College	My sincerest apologies for not meeting the deadline: we are in the midst of drafting multiple standards in response to new provincial legislation.

of Physicians and Surgeons of Alberta	On behalf of CPSA, thank you for the opportunity to review the draft updates to your bylaws and provide feedback. The bylaws were shared with the Governance and Accreditation teams as our subject matter experts.
	
	Please let me know if you have any questions or require clarification.
	
	<u>The Affairs of the College Bylaw</u>
	• Definitions
	  ○ CPSM: it was suggested that adding "of Manitoba" may make the acronym a little clearer
	• Clause 7: it looks like there may be a formatting error – it is unclear whether the stem is missing or if subclause (a) should be the stem.
	  ○ Subclause (b): please excuse our ignorance on Manitoba's electoral districts – clause 4 mentions Manitoba being divided into two electoral districts, but this subclause mentions four (and the "Schedule A" clause 4 mentions being attached to the Bylaw does not appear to be attached to the draft).
	  ○ Additionally, clause 110 only lists 3 of the 4 districts listed in 7(b).
	• Clause 28: CPSM may wish to consider clarifying how "accidental" failure to comply will be determined.
	
	• Clause 36: minor housekeeping note, but the numbering format changes from numeric/alphabetic to multilevel numbering.
	• Clause 106: if correspondence may be sent electronically, is there value in addressing that here?
	
	<u>Accredited Facilities Bylaw</u>
	• Copy edits:
	  ○ Clauses 6.3 and 6.4 are missing periods.
	  ○ Clause 13.2: no punctuation on the subclauses.
	  ○ Clause 17.1: this sentence appears at the beginning of clause 15.15 – is the repetition intentional?
	  ○ Clauses 21.2: no punctuation on the first two subclauses.
	  ○ Clause 27.2: no punctuation on 27.2.5 or 27.2.6; 27.2.7 starts with a capital letter and ends in a semicolon instead of a period.
	• Clause 1.1.6: CPSM may wish to consider adding the highlighted:
	  ○ Section 1.1.6 – "diagnostic imaging facility" means a place where imaging techniques are used for diagnostic purposes including radiography, ultrasound (including echocardiography), computed tomography, magnetic resonance imaging, fluoroscopy, bone densitometry (DEXA/DXA), mammography, nuclear medicine (including SPECT, SPECT/CT, PET, PET/CT, PET/MRI).

- Clause 2: CPSM may wish to consider providing standards for general anesthesia, regional anesthesia, nitrous oxide, Penthrox and IV sedation (moderate and deep) only – see example:

IV sedation	Altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. No distinction is made between light and deep IV sedation for credentialing or monitoring purposes. The provision of IV sedation includes, but is not limited to, the use of any IV agent for this purpose or of nitrous oxide in a greater than 50% concentration. All of the above require the monitoring of vital signs. For the purposes of this document, the use of oral pre-medication alone or in combination with local anesthesia is NOT defined as IV sedation.
Minimal sedation	("Anxiolysis") is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, airway reflexes and ventilatory and cardiovascular functions are unaffected. Note: For the purpose of this document, sole or minimal use of oral anxiolysis for the purpose of pre-medication is not considered sedation.
Moderate sedation	("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Note: Reflex withdrawal from painful stimulus is NOT considered a purposeful response.
Deep sedation	Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Note: Due to the potential for rapid and profound changes in sedative/anesthetic depth and the lack of antagonist medications, patients that receive potent intravenous induction agents (including, but not limited to Propofol, Ketamine, Etomidate, and Methohexital) must receive care that is consistent with deep sedation even if moderate sedation is intended. These medications must be administered by a physician qualified to provide deep sedation.
Sedation	An altered or depressed state of awareness or perception of pain brought about by pharmacologic agents, and which is accompanied by varying degrees of depression of respiration and protective reflexes.

CAS - https://www.cas.ca/CASAssets/Documents/Practice-Resources/Guidelines/Appendix-6_2024.pdf
CPS - https://cps.ca/en/documents/position/recommendations-for-procedural-sedation-in-infants-children-and-adolescent

- Clause 4: considerations should be made for the procedure itself and risks associated to the procedure that expand beyond the device type reusable versus single-use and the patient safety aspects of the procedure.

The use of a single-use disposable cystoscope does not eliminate the need for an accredited facility, because accreditation is intended to ensure the safety of the procedure, not simply the safety of the instrument. While disposable cystoscopes remove the risks associated with cleaning, disinfection, and sterilization of reusable devices, they do not change the inherent risks of cystoscopy. A diagnostic cystoscopy involves instrumentation of the urinary tract, which is managed as a sterile body site using aseptic technique. Although the procedure is considered low risk, patients may still experience complications such as vasovagal reactions, urinary retention, urinary tract infection,

	clinically significant bleeding, urethral trauma, or, in rare cases, bladder perforation. In addition, if an abnormality is identified, a biopsy could increase the procedural risk. Focusing solely on the use of a single-use cystoscope may inadvertently lead facilities to overlook the broader procedural and patient safety expectations associated with cystoscopy. For example, while many diagnostic cystoscopies are performed under local anesthesia, some patients require intravenous sedation, which necessitates enhanced patient monitoring, recovery capabilities, and appropriately trained personnel. These requirements are independent of whether a single-use or reusable cystoscope is used and reinforce that accreditation should be based on the overall risks and safety requirements of the procedure rather than the type of medical device. Accreditation ensures infection prevention and control practices, trained personnel, emergency equipment, medication management, patient assessment, informed consent processes, documentation, quality assurance, and the ability to recognize and respond to unexpected complications are in place. These requirements apply regardless of whether the cystoscope is reusable or single use. Therefore, while disposable cystoscopes reduce one aspect of procedural risk of medical device reprocessing, they do not eliminate the need for an accredited environment that can safely support the procedure and manage the patient before, during, and after cystoscopy. • Clause 8: just for information/consideration, CPSA's NSHF program is undergoing a major quality assurance process regarding patient safety events and will likely move to adopt (with Council approval) the Joint Commission and the National Quality Forum paper/framework on Aligning Patient Safety Event Reporting. • Clause 22.1.3: are there examples of/links to self-review/quality improvement that could be provided? • Clause 23.1.3: are there parameters for staff to determine whether the adult is responsible? • Clause 27.2.4: missing word? Should it be "facilities **are** sufficient"? **Chantelle Dick, BA - Crim** (she/her) Manager, Standards of Practice D: 780-969-4987 | 1-800-561-3899 ext. 4987 C: 780-717-2573 2700 - 10020 100 Street NW Edmonton AB T5J 0N3 **chantelle.dick@cpsa.ab.ca | cpsa.ca**

Feedback on Draft Accredited Facilities Bylaw Amendment — College of Physicians and Surgeons of Manitoba (CPSM) LETTER 1

Preamble

We welcome the opportunity to provide feedback on the proposed amendments to the Accredited Facilities Bylaw.

As drafted, the amendments would bring ketamine used for psychiatric indications and, prospectively, other psychedelic substances such as psilocybin and MDMA as they progress through Health Canada's regulatory pathway within a framework designed for higher-acuity anesthetic and surgical procedural sedation. Low-dose oral, sublingual, or intramuscular therapy delivered over a multi-hour session with psychotherapist facilitation and medical oversight is materially different from the intravenous anesthetic use that this section was originally intended to govern. Applying one undifferentiated standard to both contexts' risks creating barriers that are disproportionate to the service's actual risk profile.

We respectfully recommend that CPSM consider creating a distinct section within the Accredited Facilities Bylaw for Psychedelic-Assisted Psychotherapy (PAPT), rather than placing this service within the existing procedural sedation framework. A dedicated section would allow the College to regulate PAPT on its own terms, consistent with emerging clinical evidence and approaches used in other provinces, while continuing to protect patient safety and support safe, appropriately governed access for Manitobans. Should the College prefer to proceed by amending the existing bylaw language rather than creating a new section, we offer the following article-specific feedback and recommendations below.

Category	Current / Draft Bylaw Provision	Concern	Feedback
1. Route- / substance-based ketamine trigger	**CPSM DRAFT PROPOSES A CHANGE** **CURRENT** Art. 13.3.3.xi: only intravenous ketamine administration triggers accreditation. **PROPOSED (DRAFT)** Art. 13.3.3.xi: any route, any formulation (incl. compounded) triggers accreditation, excluding topical and palliative-care use.	The draft ties the accreditation requirement to the substance itself, regardless of whether psychotherapy is involved. It is a route/substance-based test rather than a function-based one. A route/substance-based trigger captures ketamine used for all indications unrelated to psychiatric care (e.g., pain management, anesthesia) under the same accreditation regime.	CPSM consider a separate PAPT-specific section for ketamine within the bylaw that is consistent with the PAPT definition used in Alberta. *E.g. when ketamine (or another designated substance) is administered as a central and linked component of psychotherapy for a psychiatric disorder.* Where a route/substance-based approach is retained, recommend the bylaw explicitly distinguish Psychedelic Assisted Psychotherapy (PAPT) use from other clinical ketamine use (e.g., pain, anesthesia) to avoid over-capturing lower-risk applications.
2. Medical Director qualifications	**NO CHANGE IN CPSM DRAFT — CLARIFICATION REQUESTED** **CURRENT** Art. 25.1 / 7.2: facility must appoint a "medical director" who is a registrant "acceptable to the Committee."	CPSM's draft does not specify any psychiatric oversight requirement, despite expanding the scope of substances/routes that trigger accreditation.	CPSM should create a separate PAPT-specific section and clarify whether psychiatric involvement in the medical director role or in the role of prescribing, is intended for accredited facilities. It would be helpful to clarify the overall role of psychiatry in the service model.

Category	Current / Draft Bylaw Provision	Concern	Feedback
3. Patient care — procedural sedation attendant	**NO CHANGE IN CPSM DRAFT — WE PROPOSE AN AMENDMENT** **CURRENT** Art. 23.1.5: a patient receiving procedural sedation must be attended by a registered nurse or a registrant (i.e., a physician/CPSM member) who is not assisting in the procedure.	As written, only a registered nurse or a CPSM registrant qualifies as the dedicated sedation attendant, other regulated practitioners, are not named even though they may independently meet the underlying competency requirements described in the Art. 12 definition of procedural sedation (monitoring, vital signs, airway management). This may unnecessarily narrow staffing options for member clinics that already credential NPs for this role.	Recommend Art. 23.1.5 be amended to permit any **regulated health professional** who meets the training and competency standard implied by the Art. 12 definition of procedural sedation.
4. Patient care — procedural sedation administration/supervision	**NO CHANGE IN CPSM DRAFT — WE PROPOSE AN AMENDMENT** **CURRENT** Art. 23.1.4: procedural sedation must be administered by or under the direct supervision of a registrant with appropriate training acceptable to CPSM to provide procedural sedation.	As with Art. 23.1.5, this provision restricts the administering/supervising role for procedural sedation to a CPSM registrant, regardless of whether another regulated practitioner (e.g., an NP) holds equivalent training and is otherwise authorized within their scope of practice to administer or supervise sedation. This may limit clinical staffing models particularly where other practitioners have documented sedation training and competency acceptable under Art. 12.	Recommend Art. 23.1.4 be amended to permit administration and/or supervision by any **regulated health professional** with training acceptable to CPSM to provide procedural sedation acting under the registrants direction.

Category	Current / Draft Bylaw Provision	Concern	Feedback
5. Continuous physician presence — low-dose PAPT	**NO CHANGE IN CPSM DRAFT — WE PROPOSE AN AMENDMENT** **CURRENT** Art. 23.2.1: a registrant who has been granted privileges must be in the room at all material times during the performance of a procedure in the facility.	This requirement appears drafted for higher-acuity sedation/surgical contexts and does not distinguish for the risk profile of low-dose PAPT (e.g., low-dose oral/sublingual/IM ketamine), typically facilitated primarily by a trained psychotherapist under medical practitioner oversight over a multi-hour session. Applied literally, it requires continuous, uninterrupted in-room physician presence for every session regardless of dose/route.	If Art. 23.2.1 is retained, CPSM should add a risk-stratified qualifier. For lower-risk, low-dose PAPT, CPSM should permit monitoring and oversight by either the registrant or another trained and authorized **regulated health professiona**l acting under the registrant's direction. The bylaw should define when in-room physician presence is required based on risk stratification and when immediate availability of the registrant or trained and authorized **regulated health professional** is sufficient, based on factors such as dose, route, and patient risk.

To the College of Physicians and Surgeons of Manitoba (CPSM),

Re: Public Consultation – Feedback on Proposed Bylaw Changes Regarding Accredited Facilities for Non-IV Ketamine Routes

We welcome the opportunity to participate in this public consultation regarding the proposed bylaw revisions to expand the accredited facilities listing. We deeply appreciate the College's commitment to patient safety and the oversight of evolving clinical practices. Thank you for allowing us to contribute our perspective to this important regulatory dialogue.

We are writing in response to the College's public consultation regarding the proposed bylaw revisions that would expand the accredited facilities listing to include all routes of ketamine administration (intramuscular [IM], sublingual [SL], nasal, and oral), alongside intravenous (IV) administration.

While we strongly support safe clinical governance and high standards of patient care, we do not believe it is reasonable or compassionate to include non-IV routes of ketamine within the same accredited facility mandate as IV administration. Based on clinical evidence and practical care delivery models, non-IV routes carry distinct safety profiles, lower technical invasiveness, and reduced risk profiles compared to IV administration, making an identical accreditation framework unnecessary, overly restrictive, and detrimental to patient access.

We respectfully submit the following evidence and precedents for your consideration:

1. Regulatory Precedent in Other Canadian Jurisdictions (British Columbia)

Regulatory precedent across Canadian jurisdictions recognizes a clear distinction between intravenous (IV) and non-intravenous ketamine administration:

• The College of Physicians and Surgeons of British Columbia (CPSBC), in its document "Interim Guidance: Ketamine Administration via Intramuscular, Oral, Sublingual, and Intranasal Routes as Treatment for Mental Health Conditions and Chronic Pain in the Community Setting" (Effective August 10, 2021; Last revised August 11, 2025, Version 1.3), explicitly distinguishes IV administration from non-IV routes. CPSBC mandates that IV ketamine be restricted to hospital settings or accredited non-hospital medical/surgical facilities, while allowing non-IV routes (IM, oral, sublingual, intranasal) in community settings under standard medical guidance and risk assessment, rather than requiring full non-hospital facility accreditation.

2. Safety and Tolerability Profiles of Non-IV Ketamine

Unlike IV administration, which involves continuous venous access and rapid bioavailability adjustments, non-IV routes (such as IM and SL) have demonstrated strong safety and

tolerability in community and outpatient psychiatric settings without requiring invasive IV facility infrastructure.

• Tsang et al. (2023) evaluated intramuscular and sublingual ketamine in outpatient psychiatric treatment and confirmed the safety, tolerability, and feasibility of these routes (*Tsang, V. W. L., Tao, B., Dames, S., Walsh, Z., & Kryskow, P. Safety and tolerability of intramuscular and sublingual ketamine for psychiatric treatment in the Roots to Thrive Ketamine Assisted Therapy Program: A retrospective chart review. Therapeutic Advances in Psychopharmacology, 2023, 13, 1–14).*
• Clinical implementation models, such as the Roots To Thrive framework, further demonstrate that non-IV ketamine can be delivered safely and effectively in outpatient, group, and community-of-practice settings *(Dames, S., Kryskow, P., Tsang, V. W. L., & Argento, E. A clinical protocol for group-based ketamine-assisted therapy in a community of practice: The Roots To Thrive model. Frontiers in Psychiatry, 2025, 16, 1568017; Dames, S., Kryskow, P., & Watler, C. A cohort-based case report: The impact of ketamine-assisted therapy embedded in a community of practice framework for healthcare providers with PTSD and depression. Frontiers in Psychiatry, 2022, 12, 803279).*

3. Unnecessary Barriers to Care and Access Restrictions

Classifying all non-IV routes under the strict accredited facility bylaw creates substantial administrative, logistical, and financial barriers for community providers and patients. Restrictive administrative hurdles directly impede timely access to vital mental health care for vulnerable and high-need populations, including first responders, healthcare workers, and individuals with treatment-resistant conditions or chronic pain.

• Tsang et al. (2026) highlight how systemic and regulatory barriers disproportionately hinder patient access to novel psychedelic-assisted therapies *(Tsang, V. W. L., Roney, C., Kryskow, P., & Dames, S. Improving access to psilocybin-assisted therapy: barriers, challenges, and recommendations. Front. Public Health, 2026, 14:1767210).*
• Research on specific populations, including firefighters and first responders seeking ketamine-assisted therapy for PTSD and comorbid conditions, demonstrates the essential need for accessible, flexible outpatient care structures (*Tsang, V. W. L., Walia, T., Sattler, K., & Kryskow, P. Barriers and access to care for firefighters with post-traumatic stress disorder seeking ketamine-assisted therapy: A qualitative study. JOEM, 2025;*
Tsang, V. W. L., Kennedy, M. K., Walia, T., Arksey, E., Dames, S., & Kryskow, P. Ketamine-assisted therapy outcomes for first-responders with comorbid mental health diagnoses. JOEM, 2025;
Tsang, V. W. L., Lin, M. C., Choles, C. A., & Kryskow, P. The effect of ketamine-assisted group therapy on treatment-resistant mental health conditions in firefighters: A prospective observational case series. JOEM, 2025).

4. Broad Therapeutic Applications and Novel Outpatient Models

Non-IV ketamine is routinely integrated into diverse therapeutic paradigms—such as group-based therapy, eating disorder recovery, and multi-modal adjunct tools—where IV infrastructure is clinically unnecessary.

• Non-IV ketamine protocols have proven effective in specialized psychiatric care, including eating disorders and community support models *(Jeletzky, L., Dames, S., Kryskow, P., & Tsang, V. W. L. Ketamine-assisted therapy within a community of practice: A novel approach to disordered eating. Therapeutic Advances in Psychopharmacology, 2025; Tsang, V. W. L., Ragazan, D. C., Kryskow, P., Walsh, Z., & Dames, S. A pilot study comparing a community of practice program with and without concurrent ketamine-assisted therapy. Journal of Psychoactive Drugs, 2024, 56(5), 627–636)*.
• Research also supports the synergistic integration of adjunct non-invasive tools and novel frameworks to enhance outcomes without requiring complex surgical-grade facility accreditation *(Tsang, V. W. L., Tao, B., Olthuis, R., Allard, P., Bhanot, S., Wong, S., & Kryskow, P. The effect of the Apollo Neuro device on anxiety among participants who underwent ketamine-assisted therapy. Journal of Psychiatric Research, 2025, 191, 678–683)*.

5. Broader Context in Psychedelic Science and Practice

The evolving literature across psychedelic-assisted modalities—including training models, harm reduction, and collaborative care—emphasizes proportional regulation that balances patient safety with equitable access and evidence-based practice:

• *Magar, V., Robbins, M., Fernández (Lobo Blanco), Ó. M. L., Ali, I. L., Anderson, B., Grob, C., Henningfield, J. E., Kryskow, P. A., Kuiper, H., Loizager-Velder, A., Rush, B., Volat, M., & Iron Robe, S. Indigenous Knowledge Systems & Psychedelic Science: Towards Ethical and Reciprocal Collaboration. Journal of Psychopharmacology, 2026.*
• *Kryskow, P., Stamets, P., La Torre, J., Sattler, K., Tsang, V. W. L., & Williams, M. "The mushroom was more alive and vibrant": Patient reports of synthetic versus organic forms of psilocybin. Journal of Psychedelic Studies, 2024.*
• *Dames, S., Watler, C., Kryskow, P., Allard, P., Gagnon, M., Taylor, W., & Tsang, V. W. L. Psychedelic-assisted therapy training: An argument in support of firsthand experience of nonordinary states of consciousness in the development of competence. Psychedelic Medicine, 2024.*
• *Dames, S., Watler, C., Miller, K., Laurie, R. W. E., Tsang, V. W. L., Olthuis, R., Allard, P., Argento, E., & Kryskow, P. Adapting the safe consumption site model for patient-procured MDMA. Canadian Health Policy, 2023.*
• *Christie, D., Yazar-Klosinski, B., Nosova, E., Kryskow, P., Siu, W., Lessor, D., & Argento, E. MDMA-assisted therapy is associated with a reduction in chronic pain among people with post-traumatic stress disorder. Frontiers in Psychiatry, 2022.*

Conclusion

We respectfully urge the College of Physicians and Surgeons of Manitoba to differentiate intravenous ketamine from non-intravenous routes (IM, SL, nasal, oral) in its regulatory framework, following the established approach of jurisdictions like British Columbia. Establishing proportionate, route-specific safety standards—rather than imposing full facility accreditation on all non-IV routes—will preserve high standards of patient safety while ensuring Manitoba patients maintain access to safe, evidence-based mental health therapies. There is substantial safety data regarding ketamine use in community settings and to include non-IV routes would not be evidence informed.

We have requested [redacted] to submit a letter for the College for review, her letter is attached to this email.

Thank you for considering our feedback during this consultation process.

Sincerely,

[redacted]

[redacted]

LETTER 3

August 20, 2026

To: College of Physicians and Surgeons of Manitoba
Re: Public Consultation—Proposed Accredited-Facility Requirements for Non-Intravenous Ketamine Administration

Dear Members of the College,

Thank you for the opportunity to provide feedback on the proposed bylaw changes concerning ketamine administration. I strongly support clear clinical standards, appropriate oversight, and regulatory approaches that protect patients receiving ketamine-assisted treatment. My concern is that extending an accredited-facility requirement to all non-intravenous routes of ketamine administration—intramuscular, sublingual, oral, and intranasal—would be disproportionate to the relevant risks, unsupported by the available evidence, and likely to reduce access to care without a demonstrated patient-safety benefit.

I offer these comments as a [redacted]

[redacted] clinicians who practise in diverse community settings reinforces an important regulatory principle: safety is achieved through proportionate standards, competent practitioners, clear clinical protocols, and accountable systems of care—not solely through the physical designation of a facility.

Route-specific regulation is warranted

Ketamine is not a single, uniform intervention from a regulatory or operational standpoint. The route of administration materially affects onset, pharmacokinetics, degree of invasiveness, capacity for dose titration, monitoring needs, and the clinical infrastructure required. Intravenous ketamine involves venous cannulation, direct vascular access, and rapid administration and titration; it is therefore reasonable for regulators to apply a distinct and more intensive facility standard to IV services.

[redacted]

[redacted]

Non-IV routes do not present the same procedural characteristics. Intramuscular, sublingual, oral, and intranasal administration are routinely delivered in ambulatory and community-based medical contexts. They can be governed through appropriate patient selection, informed consent, pre-treatment assessment, trained staff, emergency preparedness, observation, discharge criteria, continuity of care, and quality-assurance processes—without requiring infrastructure intended for invasive medical or surgical procedures.

A regulatory framework that treats all ketamine routes identically risks conflating medication-related risk with procedure-related risk. The relevant question is not whether ketamine should be regulated carefully—it should—but whether full accredited-facility status is necessary and evidence-based for every route. ***For non-IV administration, the available evidence does not establish that this requirement is necessary to achieve safe care.***

Published community-based experience

[redacted] has contributed directly to the evidence base on non-IV ketamine-assisted therapy. A retrospective chart review of intramuscular and sublingual ketamine treatment in an outpatient psychiatric setting found these routes to be feasible, tolerable, and safe when provided within a structured clinical program with appropriate screening, monitoring, preparation, and follow-up (Tsang et al., Therapeutic Advances in Psychopharmacology, 2023).

This work reflects real-world delivery rather than a narrowly controlled laboratory environment and is therefore particularly relevant to regulatory decisions about community practice. [redacted] clinical protocols also describe delivery of ketamine-assisted therapy within group-based and community-of-practice models while maintaining medical oversight, therapeutic support, clinical governance, and patient-safety procedures (Dames et al., Frontiers in Psychiatry, 2025). Related work involving health-care providers with PTSD and depression further demonstrates the potential for structured community models to provide meaningful care outside hospital or surgical-facility settings (Dames et al., Frontiers in Psychiatry, 2022).

These findings are not an argument for unregulated practice. They support a more appropriate alternative: robust, route-specific standards for non-IV ketamine, rather than an accreditation pathway designed for clinically different procedures.

Regulatory precedent and safeguards

British Columbia offers a useful Canadian precedent. The College of Physicians and Surgeons of British Columbia distinguishes IV ketamine from intramuscular, oral, sublingual, and intranasal routes in its interim guidance on ketamine for mental-health conditions and chronic pain. IV ketamine is limited to hospitals or accredited non-hospital medical and surgical facilities, whereas non-IV administration may occur in community settings subject to professional standards, clinical judgment, and appropriate risk assessment.

[redacted]

[redacted]

Manitoba could similarly establish a clear framework for non-IV ketamine that includes:

- Physician or Nurse Practitioner assessment, diagnosis, prescribing, and ongoing accountability
- Medical and psychiatric screening for contraindications and risks
- Individualized dose and route selection
- Informed consent that addresses anticipated acute effects and adverse events
- Defined observation, recovery, escort, and discharge procedures
- Trained clinicians and staff, emergency preparedness, and transfer protocols
- Documentation, adverse-event reporting, review, and quality improvement
- Appropriate integration with primary care, psychotherapy, and continuing mental-health treatment

These standards would provide meaningful patient protection while recognizing that safe care depends on clinical competence and systems of accountability rather than a surgical-grade facility designation.

Access is a patient-safety issue

Accredited-facility requirements carry substantial financial, administrative, logistical, and geographic consequences. For people with treatment-resistant depression, PTSD, chronic pain, and complex comorbid conditions, these requirements may delay treatment, concentrate services in larger urban centres, and make care inaccessible to patients who cannot travel or absorb increased costs.

This concern is particularly relevant to first responders, health-care workers, and others living with occupational trauma, who may benefit from structured outpatient treatment programs. The published experience from [redacted] shows that properly trained clinicians have been delivering non-IV ketamine within thoughtful, medically governed outpatient models **for decades.**

Access and safety should not be framed as competing values. In mental-health care, delayed, unavailable, or geographically inaccessible treatment can itself create clinical harm. Regulatory burden should therefore be matched to demonstrated risk and calibrated so that it protects patients without unnecessarily excluding them from care.

Recommendation

I respectfully recommend that the College maintain a clear distinction between IV and non-IV ketamine administration. IV ketamine may reasonably warrant hospital or accredited-facility delivery because of its invasive nature and distinct monitoring considerations. However, applying the same facility-accreditation requirement to IM, sublingual, oral, and intranasal ketamine is not currently evidence-informed nor supported by decades of evidence of community based mental health treatment programs across North America.

[redacted]

[redacted]

A route-specific framework would preserve high standards of patient safety while reflecting the published evidence, established Canadian regulatory precedent, and substantial clinical experience with well-governed community ketamine programs. It would also support the responsible development of a trained community workforce capable of providing safe, accessible, and accountable care.

Thank you for considering these comments. I would be pleased to provide further information about [redacted] clinical model, published safety data, clinician-training approach, and community-based care protocols.

Sincerely,

[redacted]

[redacted]

LETTER 4

College of Registered Nurses of Manitoba

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August 20, 2026

College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Avenue
Winnipeg, MB R3J 3T7

VIA EMAIL
CPSMconsultation@cpsm.mb.ca

Attention: Amendments to the *Accredited Facilities Bylaw*

Dear Dr. Charles Penner and Dr. Ainslie Mihalchuk,

On behalf of the College of Registered Nurses of Manitoba (CRNM), I am writing to provide feedback on the proposed amendments to the *Accredited Facilities Bylaw*. We support the proposed amendments as drafted and suggest one item for further consideration (detailed below).

Increasingly, some registrants have indicated an interest in and made inquiries about providing substance-assisted psychotherapy. As this area of practice has quickly grown and continues to evolve, corresponding adjustments to this bylaw are beneficial. In particular, we welcome the proposed expansion in section 13.3.3.xi. relating to ketamine administration. It is critical that regulation keep up with changes in methods of administration as such developments occur. This amendment will facilitate effective and clear communication with other healthcare professionals (such as RNs and NPs) who may be involved in providing ketamine-assisted psychotherapy, which will also enhance collaborative care in this area.

Another substance that is being more frequently mentioned of late is Psilocybin. In the interest of bylaw clarity, we would encourage CPSM to consider one of the following:

- amending section 13.3.3.xii. by removing "MDMA (3,4-methylenedioxymethamphetamine)" and instead inserting the following "psychedelic and/or hallucinogenic drugs," **or**
- amending section 13.3.3.xii. to add "and Psilocybin (4-phosphoryloxy-N,N-dimethyltryptamine)" right after "MDMA (3,4-methylenedioxymethamphetamine)"

Interest in providing Psilocybin-assisted psychotherapy appears to be growing, therefore it seems prudent to ensure that the bylaw clearly captures it. This would remove any doubt or debate around whether Psilocybin is currently covered under the bylaw.

We appreciate the opportunity to provide input on these proposed bylaw amendments. We hope our feedback and observations are helpful.

Sincerely,

Deb Elias RN

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

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Accredited Facilities Bylaw

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

The College of Physicians and Surgeons of Manitoba

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

Effective Date January 1, 2019
With revisions up to and including June 25, 2025

Table of Contents

Preamble

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

PART A – DIAGNOSTIC FACILITIES

Article 1 – Definitions

1.1. In Part A of Bylaw:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 2 – Application of this Part

Part A of this Bylaw applies as follows:

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

[1] 183(1) This section applies to any facility in which a member performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than

(a) a facility that is designated as a hospital under *The Health Services Insurance Act*;

(b) a hospital or health care facility operated by the government, the government of Canada or a municipal government; and

(c) a facility or class of facility exempted by regulation from the application of this section.

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

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

Article 3 – Facility Accreditation

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

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

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

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

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

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

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

Accreditation Process

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

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

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

Full Accreditation

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

Accreditation Not Granted

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

Conditional Accreditation

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

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

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

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

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

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

Accreditation Status Review

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

Temporary Accreditation

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

Role of Facility Director During Accreditation

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

Article 4 – Maintenance of Accreditation

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

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

Article 5 – Renewal of Accreditation

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

Article 6 – Variance or Withdrawal of Accreditation

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

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

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

6.4 Council may withdraw accreditation in accordance with the RHPA

Article 7 – Facility Director

7.1. A facility must have a Facility Director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.8.15.i. equipment.

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

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

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

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

Article 8 – Appeal

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

Article 9 – Fees

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

Article 10 – Physician Office Laboratory

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

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

Article 11 – Transition

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

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

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

PART B – NON-HOSPITAL MEDICAL OR SURGICAL FACILITIES

Article 12 – Definitions

12.1. In Part B of this Bylaw:

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

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

"Committee" means the Program Review Committee of CPSM.

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

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

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

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

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

"~~-~~procedural **oral sedation**" means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents given orally before a procedure under supervision and ~~with~~ which may be ~~is~~ accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient ~~can~~ is likely to be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states. Procedural oral sedation should have the same credentialing or monitoring purposes as for procedural sedation.

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

“procedural sedation” means an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained, and

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

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

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

Article 13 – Application of this Part – Procedures Requiring Accreditation

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

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

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

13.3.3.i.a. resection of a deep, major or complicated lesion;
13.3.3.i.b. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;

13.3.3.ii. flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;
13.3.3.iii. assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;
13.3.3.iv. the following Ophthalmological Procedures:
13.3.3.iv.a. cataract surgical procedures
13.3.3.iv.b. corneal laser procedures
13.3.3.iv.c. retinal procedures limited to scleral buckling and vitrectomies
13.3.3.iv.d. Lasik therapeutic procedures
13.3.3.v. the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;
13.3.3.vi. liposuction procedures;
13.3.3.vii. hair transplantation;
13.3.3.viii. venous sclerotherapy;
13.3.3.ix. hyperbaric oxygen therapy;
13.3.3.x. hemodialysis;
13.3.3.xi. intravenous Ketamine administration;
13.3.3.xii. MDMA (3,4-methylenedioxymethamphetamine); ~~or~~
~~13.3.3.xii.~~13.3.3.xiii. ~~Sleep Clinics~~ Sleep Medicine

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

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

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

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

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

Article 15 – Facility Accreditation

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

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

Accreditation Process

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

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

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

Full Accreditation

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

Accreditation Not Granted

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

Conditional Accreditation

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

15.9 Where conditional accreditation is granted, the Committee must:

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

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

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

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

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

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

15.12.1 extend conditional accreditation;

15.12.2 direct an inspection;

15.12.3 withdraw the conditional accreditations.

Temporary Accreditation

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

Term of Accreditation and Renewal

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

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

Article 16 – Maintenance of Accreditation

16.1 In order to maintain accreditation, a facility must:

- 16.1.1 comply with the relevant requirements;
- 16.1.2 perform only the procedures permitted pursuant to the facility's certificate of accreditation;
- 16.1.3 at all reasonable times, be open for investigation and inspection by the Committee, with or without notice of the Committee's intention to inspect; and
- 16.1.4 cooperate with and participate in the inspection process approved by the Committee for its type of facility.

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

- 16.2.1 a facility may not meet the requirements, standards of practice, or other standards for public safety and.
- 16.2.2 an inspection would be in the public's best interest.

Article 17 – Renewal of Accreditation

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

Article 18 – Variance or Withdrawal of Accreditation

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

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

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

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

Article 19 – Approved Procedures

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

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

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

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

Article 20 – Health Authority Agreement

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

Article 21 – Privileges

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

21.2. The Medical Director must only grant and renew privileges for a registrant to perform procedures in an accredited facility if the Medical Director is satisfied that:
- 21.2.1. the applicant is a suitable and competent candidate
- 21.2.2. the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant and
- 21.2.3. those privileges are the same as granted by Shared Health or a Regional Health Authority or are recommended through the Shared Health credentialing process and those privileges are and remain in good standing.

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

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

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

Article 22 – Standard of Care

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

22.1.3. engage in ongoing processes of self-review and quality improvement.

Article 23 – Patient Care

23.1. Anaesthetic Care

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

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

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

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

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

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

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

23.2. A registrant who has been granted privileges must:

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

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

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

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

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

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

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

Article 24 – Infection Control

24.1 A facility must:

24.1.1 use sterilization techniques,

24.1.2 store medical and dental supplies, and

24.1.3 use waste handling and disposal procedures

consistent with the standards applicable to hospitals.

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

Article 25 – Medical Director

25.1 The facility shall appoint a medical director, who is a registrant acceptable to the Committee, and who must:

25.1.1 enforce the standards of care in the facility, which include the safe and effective care of patients in the facility;

25.1.2 be responsible for the administration of the facility; and

25.1.3 provide required reporting to CPSM.

25.2 In enforcing the standards of care in the facility which includes the safe and effective care of patients, the medical director must ensure that:

25.2.1 procedures and equipment are appropriate and safe;

25.2.2 procedures are performed in accordance with current good medical care and practice;

25.2.3 sufficient numbers of appropriately trained personnel are present during procedures;

25.2.4 procedures approved by the Committee as set out in the certificate of accreditation are only performed at the facility by registrants with privileges;

25.2.5 persons who provide services to the facility have appropriate qualifications and maintain competence to perform the procedures for which the facility is accredited;

25.2.6 registrants with privileges have current basic life support skills and other skills appropriate to the clinical settings (such as advanced cardiac support, pediatric advanced life support, and airway management skills);

25.2.7 all direct patient care personnel have life support skills and there must be two such qualified personnel present at any time patients are receiving care;

25.2.8 adequate quality assurance and improvement programs, including the monitoring of infection and medical complication rates, are in place.

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

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

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

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

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

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

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

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

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

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

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

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

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

25.4.1.iii unexpected admission to hospital and/or presenting to an Emergency Department or Urgent Care within 10 days of a procedure performed;

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

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

25.4.1.vi any other major adverse patient outcome.

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

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

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

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

Article 26 – Audit and Quality Control

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

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

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

Article 27 – Annual Report

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

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

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

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

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

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

27.2.5 the number of transfers to hospital from the facility

27.2.6 list of registrants with privileges and health care staff

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

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

Article 28 – Inspections and Audits

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

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

28.1.2. renovations in the facility;

28.1.3. an adverse patient outcome;

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

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

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

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

Article 29 – Appeal

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

Article 30 – Administration Fees for Facilities

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

Article 31 – Transition

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

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

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

NOTE – The list for additional procedures for section 13.3 is on the next page.

COUNCIL MEETING
SEPTEMBER 23, 2026
NOTICE OF MOTION FOR APPROVAL

SUBJECT: The Affairs of the College Bylaw Revisions - Consultation

BACKGROUND:

At the June 24, 2026 meeting, Council updated the Code of Conduct (*Governance Policy*) to improve clarity of language and to address requirements for regular attendance, self-assessment, peer and Council assessment, continuing education, annual affirmation, and non-compliance. Amendments to The Affairs of the College Bylaw creating **section 36.1** – Suspension from Council were proposed to complement these improvements (see ***Appendix A***).

Council approved a motion that the proposed amendments to the *Affairs of the College Bylaw* be circulated to registrants and stakeholders for consultation.

Consultation began July 27, 2026 with deadline for feedback on August 27, 2026.

No consultation responses were received. It is recommended that Council approve the proposed amendment creating **section 36.1** to *The Affairs of the College Bylaw*.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

> Amendments creating section 36.1 to The Affairs of the College Bylaw be approved as presented.

Notice of Motion for Approval Briefing Note Prepared by: Mr. Mike Triggs, General Counsel

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The Affairs of the College Bylaw

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba on November 22, 2018 repealing Bylaws 1, 2, 3, 3D, 4, 5, 6, 7, 8, 9, 10 and 11 under *The Medical Act*)

Effective Date January 1, 2019

Table of Contents

PART A – DEFINITIONS

Definitions

1. Terms that are defined in *The Regulated Health Professions Act* ("RHPA") or the regulations have the same meaning in all parts of this Bylaw, unless specifically defined in this Bylaw.

2. The following definitions apply in this Bylaw:

"Bylaw" means a Bylaw of CPSM established under section 222 of the RHPA

"certificate year" means the period for which a certificate of practice is issued for a particular class of registrants

"CPSM" means the College of Physicians and Surgeons continued under section 8(b) of the RHPA

"Council Profile" means a profile or matrix of attributes, expertise and diversity approved by Council to be used by the Elections Committee to evaluate applicants for nomination for Council election.

"Councillor" means a person serving on the Council of CPSM

"elected Councillor" means a person elected to Council under clauses 180(1)(a) or (c) of the RHPA

"Executive Committee" means the Executive Committee of CPSM as established under section 22(1)(b) of the RHPA

"primary practice location" means the primary location at which a registrant is carrying on the practice of medicine

"regulations" mean regulations applicable to CPSM made under the RHPA

"RHPA" means *The Regulated Health Professions Act*

PART B – ELECTIONS AND APPOINTMENTS

Councillors Eligibility and Electoral Districts

Eligibility requirements for candidates

3. To be eligible to be a candidate for election as a Councillor, a regulated registrant must meet all of the following requirements:
   a. maintain their primary practice location in the electoral district in which they seek to be a candidate up to the election date;
   b. be nominated as a candidate for election as set out in this Bylaw;
   c. meet the requirements of s. 14 of the RHPA;
   d. not be a current member of the Board of Director or Committee Member of Doctors Manitoba;
   e. not previously held the Office of President;
   f. not previously been on Council for eight or more consecutive years.

Electoral Districts

4. For the election of regulated registrants, Manitoba is divided into two electoral districts described in Schedule A attached to this Bylaw.

Number of Elected Councillors from each Electoral District

5. The number of regulated registrants to be elected from each electoral district is:
   a. Four (4) registrants from the Winnipeg Electoral District;
   b. Three (3) registrants from the Rural Electoral District

Elections

Election Transition Provisions to Prevail

6. For the election of regulated registrants, the Election Transition provisions at section 110 shall prevail over the terms of this Bylaw until the election in 2022.

7.

a. Commencing in 2020 and continuing every second year thereafter there must be an election of regulated registrants to Council on the following schedule:

2020 - 3 Councillors from the Winnipeg Electoral District
2020 - 1 Councillor from the West Electoral District
2022 - 1 Councillors from the Winnipeg Electoral District
2022 - 1 Councillor from the North Electoral District
2022 - 1 Councillor from the East Electoral District

b. Commencing in 2026 the schedule in section 7a will continue except instead of having elections for the North and East Electoral Districts, there will be an election for two Councillors from the Rual Electoral District and in 2028 instead of having an election for the West Electoral District, there will be an election for one Councillor in the Rural Electoral District.

c. The President Elect of the Council, whether or not they have been re-elected or re-appointed as a council member, will be a member of the Council of CPSM.

d. A chart representing the composition of Council is:

Council Position	Number	Appointed	Elected	Other
Public Representative	3	Appointed by Council		
Public Representative	3	Appointed by Minister		
University of Manitoba	1	Appointed by University		
President	1			Ex Officio
Past President	1			Ex Officio
President Elect	1			Ex Officio
Associate Registrant	1		Elected by Associate registrants	
Winnipeg	4		Elected by Registrants	
Rural	3		Elected by Registrants	
Total	**18**			

Election for Regulated Associate Registrants

8. Commencing in 2019 and continuing annually thereafter there must be an election for one Councillor from the regulated associate registrants.

Procedures governing all elections, by-elections and run-off elections

9. The Registrar must supervise and administer all Council elections and may establish procedures for that purpose consistent with the Bylaws.

10. The Registrar must:
    a. use electronic processes for the circulation of election notices, forms, ballots, nominations, other documentation, and the collection of votes must be by electronic ballot.
    b. ensure that all methods of voting are secure and preserve the anonymity of the voters and the secrecy of their votes.
    c. act as the returning officer in each election.
    d. resolve any dispute or irregularity with respect to any nomination, ballot or election.

Notice of Election

11. By no later than the fourth Tuesday in March preceding an election, the Registrar must circulate written notice of the election and the applicable voters list to every regulated registrant or regulated associate registrant.

Voters List

12. The Registrar must prepare a voters list by no later than the fourth Tuesday in March in each year:
    a. for a regulated registrant election, a voters' list listing all regulated registrants who hold a current certificate of practice in one of the following classes:
        i. full practising;
        ii. provisional academic - s. 181 faculty;
        iii. provisional academic - post-certification trainee;
        iv. provisional specialty practice - limited;
        v. provisional family practice - limited;
        vi. provisional Manitoba Practice Assessment Program;
        vii. provisional public health officer.

    b. for a regulated associate registrants election, a voters list listing all regulated associate registrants who hold a current certificate of practice in one of the following classes:
        i. educational medical student;
        ii. educational physician assistant student;
        iii. educational resident;

iv. educational resident limited;
v. educational external or visiting student;
vi. physician assistant full;
vii. physician assistant academic – s. 181 faculty;
viii. clinical assistant full.

Right to examine voters list

13. Any CPSM registrant may examine the voters list prepared for an election at the CPSM office during office hours.

Correction of voters list

14. Any registrant who believes that there is an error in the voters list may report the error to the Registrar. The Registrar must investigate and must correct any error found to exist.

Nominations

15 (a) The Elections Committee shall oversee and administer the process for nominating regulated registrants and regulated associate registrants for election to Council. The Committee is empowered to establish policies and procedures to ensure the integrity, fairness and transparency of the nominations process, including but not limited to:
i. identifying and soliciting candidates,
ii. developing an application form,
iii. evaluation of candidates.

15 (b) A call for applications shall be circulated to all regulated registrants and regulated associate registrants when a vacancy is anticipated or arises due to the expiry of a term, resignation, or removal of a Council member. The call for applications must include the Council Profile and remain open for a minimum of four consecutive weeks and shall be issued no earlier than January 15 and close no later than March 5 of the election year.

15 (c) Any regulated registrant in good standing whose primary practice location is in the electoral district having the election may apply to run for election. The application must confirm their eligibility and willingness to serve, their commitment to the duties and responsibilities of Council membership and their competency criteria specified in the Council Profile.

15 (d) The Elections Committee shall evaluate all applications against the eligibility criteria set out in these bylaws and any additional competency criteria specified in the Council Profile. The Committee may disqualify candidates whose conduct or history may bring Council into disrepute.

15 (e) Upon completion of the evaluation, if the number of eligible candidates exceeds the number of vacancies, an election shall be held. If the number of eligible candidates equals

the number of vacancies, candidates shall be acclaimed. If fewer eligible candidates than vacancies exist, the applications process shall be reopened for an additional three weeks.

15 (f) Any candidate not approved to be on the slate of nominees for the upcoming election shall be notified by the Elections Committee no later than the fourth Tuesday in March preceding the date of the election and they may appeal to the Executive Committee within seven days of the notice. The Executive Committee shall review the candidate's eligibility and qualifications to determine if they are to be added to the slate of nominees for the election. The Executive Committee's decision shall be final and not subject to challenge.

Election dates

16. Any election of registrants to Council must be held on the first Tuesday in May. Ballots may be cast any time after the third Tuesday in April and the deadline for receipt of ballots in the election is noon on the first Tuesday in May.

Entitlement to vote

17. Every regulated registrant whose name is on the voters list created for an election of a regulated registrant is entitled to vote in the election .

18. Every regulated associate registrant whose name is on the voters list created for an election of a regulated associate registrant is entitled to vote in that election.

Election Procedure

19. For each election, by no later than the third Tuesday in April preceding the date of an election the Registrar must circulate to each registrant entitled to vote in an election of:
    a. regulated registrants, a form of ballot that lists under each electoral district the names in alphabetical order of all candidates nominated for that electoral district;
    b. a regulated associate registrant, a form of ballot that lists the names in alphabetical order of all candidates nominated;
    c. voting instructions, including the date and time by which ballots must be received by the Registrar;
    d. candidate biographical information in the form prescribed by the Registrar; and
    e. such other material as may be required.

Invalid ballots

20. A ballot is invalid that:
    a. is not cast in accordance with the instructions circulated by the Registrar,
    b. votes for more candidates than the number to be elected in the electoral district or the election as the case may be, or
    c. is not received by the Registrar before the deadline for receipt of ballots in the election.

Right to be present

21. Any of the candidates for election may be present at the tabulation of the election results.

Acclamation

22. The Registrar must declare that those nominated are elected by acclamation, if:
    a. for an election of a regulated associate registrant, only one regulated associate registrant is nominated,
    b. for an election of regulated registrants, the number of candidates nominated in an electoral district does not exceed the number to be elected in that district.

Procedure in the event of a tie

23. In the event of a tie vote, a run-off election must take place between the tied candidates, no later than fourteen days after the election date. The election procedure in Sections 17 to 20 applies to a run-off election, with the necessary modifications to dates and procedures implied.

Insufficient candidates

24. If insufficient candidates are nominated to elect the required number of Councillors, the Executive Committee must, within 45 days following the date nominations were due, appoint to fill the vacancy:
    a. For regulated registrants, a regulated registrant who meets the eligibility criteria for nomination in the electoral district with insufficient candidates;
    b. For a regulated associate registrant, a regulated associate registrant who meets the eligibility criteria for nomination as a regulated associate registrant.

Election results

25. The Registrar must declare elected the candidates with the highest number of votes, up to the number to be elected in the electoral district or the regulated associate registrant election as the case may be.

26. The Registrar must certify in writing as soon as possible after an election the names of the person or persons who have been elected and must give written notice of the election results to registrants.

Challenge to Election

27. Challenge to Election
    a. Any registrant who lawfully voted in the election may file a written petition challenging the election of any candidate and stating the grounds for the challenge. The Registrar must provide a copy of the challenge to the candidate whose election is disputed.
    b. The Executive Committee must hear the challenge, and the registrant challenging and the candidate whose election is disputed must be given notice of the date, time and place of the hearing.
    c. Following the hearing, the Executive Committee must report to the Council, which must declare whether the candidate whose election is disputed was duly elected. If the decision is that the candidate was not duly elected, Council must declare another eligible candidate elected.

Failure to comply

28. Any accidental failure to comply with the Bylaw or procedures set for elections does not invalidate an election.

Appointments

University Faculty selection

29. By no later than the first Tuesday in April in any year in which the Rady Faculty of Health Sciences, Max Rady College of Medicine selection of a representative to Council is required, the Registrar must request that the Dean of the Max Rady College of Medicine notify the Registrar of the name of the faculty member selected as Councillor and their alternate when they are not available, pursuant to s. 180(1)(d) of the RHPA.

Appointment of Public Representatives by Minister

30. By no later than the first Tuesday in April in any year in which the ministerial appointment of public representatives to Council is required, the Registrar must request that the Minister notify the Registrar of the names of the ministerial appointments to Council.

Appointment of Public Representatives by the Council

31. On or before the first Tuesday in April in any year which Council is to appoint a public representative, the Executive Committee shall submit to Council one or more candidates who meet the criteria established by Council as to identified skills or attributes required of public representatives.

32. If more candidates are nominated than there are positions to be filled, the Registrar must conduct an election by Councillors of public representatives according to the following process:
    a. no later than the fourth Tuesday in April preceding the date of an election, provide to each Councillor:
        i. a form of ballot that lists the names in alphabetical order of all candidates nominated;
        ii. voting instructions, including the date and time by which votes must be received by the Registrar; and
        iii. such other material as may be required.
    b. The Registrar must declare elected the candidate(s) with the greatest number of votes up to the number required to be elected and report the results to Council.
    c. In the event of a tie vote, the President shall cast the deciding vote.

Vacancies on Council

33. If an elected Councillor or a Councillor appointed by Council ceases to hold office before the end of their term, the Council shall conduct a by-election in the same manner as a scheduled election, with all necessary modifications to dates and procedures implied.

Term of office

34. Unless elected to fill a vacancy, the term of office of Councillors begins immediately after the annual meeting of Council following the election and after the Councillor has signed the oath of office, and is:
    a. For regulated registrants, including the Max Rady College of Medicine appointee, a four-year term;
    b. For regulated associate registrants, a one-year term;
    c. For public representatives, a four-year term, or, for government appointed public representatives, the term designated by the government to a maximum of four years.

35. Councillors elected to fill a vacancy take office immediately upon election and signing the oath of office and hold office for the unexpired portion of the vacant term.

Council registrants ceasing to hold office

36. An elected Councillor or a Councillor appointed by Council ceases to hold office if the Councillor:
    a. resigns by written notice delivered to the Registrar;
    b. ceases to be eligible for election or appointment to the Council, unless the Councillor loses eligibility only by reason of parental leave or illness;
    c. is censured pursuant to section 102 of the RHPA or an Inquiry Panel makes a finding against the registrant pursuant to section 124 of the RHPA;
    d. ~~is absent, without cause, from three consecutive Council meetings, unless previously excused by the Council;~~
    e. is removed from Council in accordance with s. 20(5) of the RHPA governing breach of the Oath of Office.
    f. is removed for breach of the Councillor and Committee Code of Conduct located in the Governance Policy;
    g. dies; or
    h. is determined to be permanently mentally incapacitated;
    i. becomes a member of the Board of Directors or Committee of Doctors Manitoba.

36.1 **Suspension from Council**

36.1.1 **Application**

This section does not apply to public representatives appointed by the Minister or Council pursuant to sections 30 and 31.

36.1.2 **Voluntary withdrawal**

Where a Councillor:

- has been charged with professional misconduct under *The Regulated Health Professions Act,* or
- is the subject of an investigation by the Investigation Committee,

The President may request that the Councillor voluntarily withdraw from participation as a member of Council pending the resolution of the matter.

36.1.3 **Authority to suspend**

Despite section 36, the Council may, by resolution passed at a duly convened meeting, suspend a Councillor from office on a temporary basis if:

a. the Councillor has been charged with professional misconduct; or
b. the Investigation Committee has appointed an investigator to investigate the Councillor's conduct.

36.1.4 Purpose and nature of suspension

A suspension under this section is an administrative and precautionary measure only, intended to:

- protect public confidence in CPSM's governance; and
- ensure the integrity of Council decision-making.

A suspension does not constitute a finding of professional misconduct and does not give rise to any presumption regarding the outcome of the investigation or proceedings.

36.1.5 Procedural fairness

The Council shall not suspend a Councillor unless:

a. the Councillor has been given written notice of the proposed suspension and the reasons for it sufficiently in advance of the meeting at which the matter is to be considered; and
b. the Councillor has been given the opportunity, prior to the meeting, to submit a written statement setting out reasons why the proposed suspension should not be imposed.

36.1.6 Effect of suspension

A Councillor who is suspended under this section:

a. is not entitled to attend Council or committee meetings;
b. is not entitled to receive materials or information circulated to Council or its committees, except as required for procedural fairness or by law; and
c. is suspended from the exercise of any powers, duties, or functions of a Councillor for the duration of the suspension, and during that period is not counted as a sitting Councillor for quorum or other governance administration purposes. For clarity, a suspension under this section does not extend or renew the Councillor's term of office or alter the date on which the Councillor's term would otherwise end.

36.1.7 Duration and review

A suspension continues until:

a. the Council resolves to lift the suspension;
b. the regulatory matter giving rise to the suspension is resolved; or
c. the Councillor otherwise ceases to hold office under section 36.

The Council may review the suspension from time to time and may maintain, vary, or terminate it by resolution.

36.1.8 Relationship to section 36

Nothing in this section limits or replaces the application of section 36. If a Councillor becomes subject to censure or automatic loss of office under section 36, section 36 applies notwithstanding any suspension under this section.

CPSM Officers

Officers

37. The officers of CPSM are:
    a. The President;
    b. The President-Elect, who will also hold the office of Treasurer;
    c. The Past President; and
    d. The Registrar

38. The officers must:
    a. throughout their term of office be regulated registrants of CPSM with a current certificate of practice;
    b. perform the duties imposed and exercise the powers given to them by the RHPA, the regulations and the Bylaws, or assigned to them by the policies of Council.

Appointment of President-Elect

39. The President-Elect must be appointed from Councillors who are regulated registrants, according to the following process:
    a. Commencing in 2018, in every second year, the Executive Committee must present a report to Council prior to December, recommending at least one nominee for the office of President-Elect.
    b. In each year when appointment to the office of President-Elect is required, the Executive Committee's report must be included in the agenda material distributed to Councillors in advance of the December Council meeting.
    c. At the December Council meeting, the Chair must ask for nominations from the floor for the office of President-Elect, provided that only Councillors present (either in person or through electronic means) are eligible to nominate from the floor, and that a Councillor may nominate himself or herself as a candidate for President-Elect.
    d. If more than one candidate is nominated for President-Elect, the Registrar must conduct an election by Councillors according to the following process:
        i. No later than the first Wednesday following the December Council meeting, provide to each Councillor:
            1. a form of ballot that lists the names in alphabetical order of all candidates nominated;

2. voting instructions, including the date and time by which votes must be received by the Registrar; and
3. such other material as may be required.

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

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

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

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

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

Term of office – President and President-Elect

40. The President-Elect and President each hold office for a maximum term of two years except in exceptional circumstances and approved by Council.

41. At the end of their two-year term as President-Elect, the President-Elect assumes the office of the President for a two-year term and at the end of the two-year term as President, assumes the office of Past-President for a two-year term.

By-election for President-Elect

42. If the office of the President becomes vacant, the President-Elect becomes President for the unexpired term and a by-election must be conducted for the office of President-Elect.

43. The procedure set forth in section 39 of this Bylaw applies to any by-election for a President-Elect, with all necessary modifications as to date and procedure implied.

PART C – COUNCIL MEETINGS AND MEETINGS OF REGISTRANTS

Council Meetings

Regular meetings

44. Council must meet at least four times in each calendar year.

Special meetings

45. The President may call a special meeting of Council, and must convene a special meeting of Council upon receipt of a written request by at least four Councillors, stating the nature of the business that is proposed to be conducted at the special meeting

Notice of Council meeting

46. The President must provide at least 14 days' notice of a meeting of Council to all Councillors, registrants of CPSM and the public, unless shorter notice is required to conduct urgent business.

47. Notice of a Council meeting may be provided to registrants and to the public by posting a notice on CPSM website. The Council agenda and materials are to be included in the notice on CPSM website, except where a private meeting is necessary to consider matters of a confidential nature or of a personal nature concerning an individual in accordance with section 25 of the Regulated Health Professions Act.

48. The accidental omission to deliver notice of a Council meeting to, or the non-receipt of such notice by, any person entitled to receive notice does not invalidate proceedings at that meeting.

Entitlement to attend meeting

49. Council meetings must be open to registrants of CPSM and the public but:
    a. only Councillors are entitled to vote; and
    b. a person who is not a Councillor may not speak without permission of the chair.

Private meeting of Council

50. In accordance with section 25(5) of the RHPA, Council may decide that an item of business on the agenda be dealt with in a private meeting. For any private meeting, all Councillors are entitled to be present but only those CPSM staff members and guests invited by Council may attend.

Voting at Council meetings

51. Each Councillor, except the Chair, is entitled to one vote on all matters. If there is an equality of votes on a matter the Chair has the deciding vote.

52. All voting at Council and Committee meetings is open. Voting for the position of President-Elect may be conducted by secret ballot if requested by any councillor.

53. A Councillor is not entitled to vote by proxy.

Procedure at Council meetings

54. The Council may meet and conduct business in person, or by video, telephone conference, web casting, or an equivalent mechanism.

55. If, in the opinion of the President, a matter is urgent business that requires immediate attention by the Council, and if, in the opinion of the President, the matter can be adequately addressed by providing information to the Council electronically or in writing, with the Council voting on a resolution included in the information by mail or by specified electronic means, the President may provide such information to the members of the Council, and allow a time for response that is, in the opinion of the President, sufficient to permit the Council members to respond.

56. In order to constitute quorum of the Council for the purposes of section 55 of this Bylaw, a simple majority of the members of Council must have voted on the resolution by specified electronic means by the time for response established by the President.

57. Council meetings must be conducted in accordance with Council policy governing the conduct of meetings and the *Interpretation Act*.

Presiding Officer

58. The President, or in the absence of the President, the President-Elect or the Past-President, must preside at a Council meeting. In the absence of the President, President-Elect and Past-President, the Councillors present must choose a Councillor to preside at the meeting.

Dispute Resolution

59. A dispute concerning the procedure to be followed at a Council meeting that is not provided for in the RHPA, Bylaws or policies of Council may be resolved in accordance with Roberts Rules of Order.

Meetings of Registrants

Annual meeting of registrants

60. Each calendar year, an annual meeting of the registrants of CPSM must be held in Manitoba, at a time and place to be determined by Council.

Special meeting of registrants

61. At any time, Council may convene a special meeting of registrants.

62. Upon receiving a written request signed by at least five percent of the regulated registrants of CPSM entitled to vote, Council must convene a special meeting registrants for the purpose specified in the request. The written request must be delivered to the Registrar and must state the nature of the business that is proposed to be considered at the meeting.

63. A special meeting of registrants convened under section 62 of this Bylaw must be held within 75 days of receipt of the written request.

Notice of meeting of registrants

64. The notice of a special meeting of registrants must state the business that will be considered at the meeting and the meeting must not consider any other business.

65. For all annual general and special meetings of registrants:
    a. Council must provide at least 14 days notice of the meeting to each registrant of CPSM and to the public;
    b. notice to registrants must include:
        i. the place, date and time of the meeting, and
        ii. any resolutions proposed to be presented at the meeting; and
    c. notice to registrants and to the public may be given by posting a notice on CPSM website.

66. The accidental omission to give notice of a meeting to, or the non-receipt of a notice by, a person entitled to receive notice does not invalidate proceedings at the meeting.

Quorum at meeting of registrants

67. A quorum for a meeting of registrants is eight voting registrants.

Procedure at meeting of registrants

68. The President or in the absence of the President, the President-Elect or the Past-President, must preside over the meeting. In the absence of the President, President-Elect and Past-President, the registrants present must elect a chairperson from among Councillors present at the meeting.

69. The President must set the agenda for the annual general meeting of registrants. The agenda must include the following items:
    a. Council reports relevant to the activities of CPSM;
    b. the CPSM's audited financial statement and report;
    c. any new Bylaws or Bylaw amendments approved by Council in the preceding fiscal year, which require registrants' approval; and
    d. the annual appointment of the auditors of CPSM.

Voting at meeting of registrants

70. A registrant of CPSM in good standing present in person at the meeting and entitled to vote at the meeting has one vote.

71. Voting will be conducted by a show of hands, unless the chairperson considers it necessary to conduct a vote by ballot.

72. In case of a tie vote, the proposed resolution does not pass.

73. Any resolution passed at an annual or special meeting of registrants, except for a resolution confirming or varying a Bylaw, must be considered by Council at its next regularly scheduled meeting.

Voting by Registrants on Bylaws Other than at a meeting

74. If Council determines that it is in the best interests of CPSM to have a bylaw amended or repealed by the registrants prior to the next annual meeting of registrants, Council may approve a vote on the proposed bylaw amendment or repeal by an electronic ballot of registrants who are entitled to vote at a meeting of registrants.

75. The vote on the bylaws by the registrants shall be conducted electronically as soon as practicable following the decision by Council to hold a vote prior to the annual meeting of registrants.

76. Registrants shall be allowed a minimum of seven calendar days in which to cast their vote following the date of the electronic distribution of the instructions and voting materials to the registrants entitled to vote. The voting materials shall include the proposed bylaw amendment(s) and a concise explanation for the rationale for the proposed amendment(s).

77. A majority of the registrants who cast a valid electronic ballot shall determine the result of the vote provided that the minimum quorum of 8 registrants cast a vote.

Entitlement to vote at meeting of registrants

78. All regulated registrants and regulated associate registrants who attend a meeting of registrants in person are entitled to vote at the meeting, except registrants in the following classes:
    a. Full - academic, visiting professor;
    b. Full - non-practising;
    c. Full - retired;
    d. Provisional - restricted purpose;
    e. Provisional - temporary locum;
    f. Provisional - non-practising;
    g. Provisional - retired;
    h. Assessment candidate - specialty practice;
    i. Assessment candidate - family practice;
    j. Assessment candidate - re-entry to practice;
    k. Educational - non-practising;
    l. Physician assistant - restricted purpose;
    m. Physician assistant - non-practising;
    n. Clinical assistant- non-practising;
    o. Physician assistant or clinical assistant retired.

Procedural issues at registrants meeting

79. A dispute concerning the procedure to be followed at a meeting of registrants that is not provided for in the RHPA or Bylaws must be resolved in accordance with Roberts Rules of Order.

PART D - PROCEDURAL RULES FOR THE INQUIRY COMMITTEE

80. Rescinded

81. The Procedural Rules for the Inquiry Committee attached as Schedule B set out certain procedures to be followed by the Inquiry Committee.

82. Neither the Code of Ethics nor the Procedural Rules for the Inquiry Committee bind or limit an Inquiry Panel in determining its own procedures in accordance with s. 117(1) of the RHPA or whether the conduct of a registrant is professional misconduct in accordance with s. 124(2) of the RHPA.

PART E - COUNCIL REGULATIONS, STANDARDS OF PRACTICE OR BYLAWS AMENDMENTS, FORMS

Amendment to Regulations or Bylaws (AM03/19)

83(a) Before making a *Regulation* or adopting a *Code of Ethics*, the Registrar must:

i. post on CPSM website an explanation of the proposed Regulation or Code of Ethics,

ii. and, within a specified time frame of at least 30 days, seek the input of registrants, the Minister of Health, and any other person Council considers necessary on the proposed change; and

iii. present Council with the results of consultation for consideration before it votes on the proposed Regulation or Code of Ethics

83(b) Before making a *Bylaw (other than the Fee Bylaw)*, the Registrar must:

i. post on CPSM website an explanation of the proposed change,

ii. and, within a specified time frame of at least 30 days, seek the input of registrants and any other person Council considers necessary on the proposed change (and if the *Accredited Facilities Bylaw* additionally seek the input of the Minister of Health); and

iii. present Council with the results of consultation for consideration before it votes on the proposed Bylaw.

83(c) Before making a new *Standard of Practice of Medicine*, the Registrar must:

i. post on CPSM website an explanation of the proposed change,

ii. and, within a specified time frame of at least 30 days, seek the input of registrants, the Minister of Health, and any other person Council considers necessary on the proposed change; and

iii. present Council with the results of consultation for consideration before it votes on the proposed Standard of Practice.

83(d) Before making a new *Practice Direction*, the Registrar must:

a. post on CPSM website an explanation of the proposed change,

b. and, within a specified time frame of at least 30 days, seek the input of registrants and any other person Council considers necessary on the proposed change; and

c. present Council with the results of consultation for consideration before it votes on the proposed Practice Direction.

84. The Registrar may make non-substantive amendments to the Bylaws, Standards of Practice, Practice Directions, and Policies such as name changes, grammatical corrections, and non-material changes.

85. Following approval by Council, every amendment to Council Regulations shall be signed by the either the President, President-Elect, or Past-President, and the Registrar, and forwarded to the Lieutenant Governor in Council for consideration.

86. Every Bylaw or Bylaw amendment enacted by the Council shall be signed by:
    a. one of the President, President-Elect, or Past-President; and
    b. the Registrar.

PART F - COMMITTEES OF COUNCIL AND DELEGATION TO COMMITTEES

87. The Council committees are:
    a. Executive Committee;
    b. Audit and Risk Management Committee;
    c. Complaints Committee;
    d. Investigation Committee;
    e. Inquiry Committee;
    f. Central Standards Committee and its subcommittees;
    g. Program Review Committee; and
    h. Elections Committee.

Terms of Reference for Council committees

88. Council must establish terms of reference for each Council committee which are set out in this Bylaw and include at least:
    a. Authority;
    b. Purpose;
    c. Composition; and
    d. Term of office for committee members if the duration of the term is other than a one-year term.

89. Each Council committee must operate within the terms of reference established from time to time by Council for that committee.

COUNCIL DELEGATED AUTHORITY TO COMMITTEES

Council Delegated Authority

90. Pursuant to section 17 of the RHPA, Council delegates the following authority:
    a. to Audit and Risk Management Committee the authority to make investment decisions on behalf of CPSM;
    b. to Executive Committee:
        i. The committee has authority delegated by Council to take the necessary actions, to hear and to determine appeals and reinstatement applications and other adjudicative matters as specified in this Part of this Bylaw.
        ii. The committee has authority delegated by Council to approve forms where approval is required by the RHPA, as set out in the Governance Policy.
        iii. The committee has the authority delegated by Council to direct a registrant to complete a specific course of action or supervised practical experience, on the advice of the Central Standards Committee pursuant to section 182(4) of the RHPA.
        iv. The committee has the authority to appoint practice auditors pursuant to section 135(1) of the RHPA. If an auditor is required to be appointed between meetings of the Executive the Chair may appoint the auditor(s) and provide the name for ratification at the next committee meeting.

v. The committee has the authority delegated by Council to employ, terminate, discipline or change the conditions of employment of the Registrar.

Council Delegated Adjudication

91. Council has delegated to the Executive Committee responsibility to take necessary actions, to hear and to decide the following matters pursuant to the powers, authorities, privileges and duties conferred or imposed upon Council in the specified sections of the RHPA and the sections necessarily ancillary to those sections:
    a. Sitting as a panel of Council pursuant to RHPA s. 38(4):
        i. registration appeals pursuant to:
        ii. **RHPA s. 38** - Denial of registration or approval of registration subject to conditions;
        iii. **RHPA s. 43** - Denial of certificate of practice or with conditions;
        iv. **RHPA s. 47** - Non-renewal due to failure to meet the requirements of the regulations;
        v. **RHPA s.183(10) and (11)**– decision to cancel certificate of accreditation and order to cease operations and consideration of written submissions to Council; or
        vi. **CPSM General Regulation s.3.73** - Request for extension.
    b. The powers delegated by Council to the Executive Committee pursuant to **section 17(1)** of the RHPA include:
        i. **RHPA s.48** - Cancellation of registration or practice certificate due to false representation or declaration or if criminal conviction for an offence relevant to their suitability to practice;
        ii. **RHPA s. 50 and s.133** - Reinstatement applications;
        iii. **RHPA s.60** – refusal of a medical corporation permit;
        iv. **RHPA s.65** – suspension or cancellation of a medical corporation permit;
        v. **RHPA s.66** – alternatives to suspending or cancelling a medical corporation permit;
        vi. **RHPA s.110** – appeals from interim suspension or interim terms and conditions;
        vii. **RHPA s.126(6**) – decision to cancel or suspended certificate of practice or registration for contravention of an order under s.126(1); and
        viii. Registrar's decision on posting a criminal conviction on a profile under **CPSM General Regulation s. 9.13.**

    Sitting in panels of three, one of whom must be a public representative, to hear appeals from the Investigation Committee, in accordance with the appeal guidelines fixed by Council, pursuant to section 108 of the RHPA.

PART G – COUNCIL AND COMMITTEE EXPENSES AND REMUNERATION

92. Council members attending meetings of the Council or of any committee of the Council shall be paid remuneration and travel expenses at such rates and in accordance with the Financial Management Policy of Council.

PART H - REGISTRAR'S DUTIES

93. The Registrar may appoint one or more Assistant Registrars to assume all the Registrar's responsibilities when the Registrar is absent. An Assistant Registrar has the same authority as the Registrar when they are acting on behalf of the Registrar. An Assistant Registrar is not required to be a registrant.

94. The Registrar is authorized to:
    a. establish forms, certificates, or other documents for the purposes of the RHPA, Regulations, or Bylaws and to require the use of such forms, certificates, or other documents by registrants and applicants for registration; and
    b. delegate such duties as they may deem fit to CPSM staff.

95. The Registrar's other duties, authority, evaluation, requirements, and conflict of interest provisions are set out in the Council's Policy - Registrar.

96. Council directs the Registrar to consider and decide on applications for registration under sections 32 and 33 of the RHPA in accordance with the Act, Regulations, Bylaws, Practice Direction on Qualifications and Registration, and any other Council policies.

Registrar Response to Alleged Serious Criminal Behaviour by a Registrant

97. Where a registrant is charged with a serious criminal offence, there are competing interests (e.g. presumption of innocence, undermining public trust, registrant's privacy rights and the legitimate rights of other individuals or organizations with whom the registrant interacts to be aware of the allegations of a serious criminal offence). The Registrar must follow the process set out below when advised that a registrant of CPSM has been charged with a serious criminal offence:
    a. On receipt of information that a registrant has been charged with a criminal offence, the Registrar must assess whether the matter is sufficiently serious to warrant referral to the Investigation Committee. In all cases where the matter is of such a nature that referral to the Investigation Committee is warranted, the matter shall be regarded as an allegation of a serious criminal offence.
    b. Where there is an allegation of a serious criminal offence against a registrant of CPSM, the Registrar must promptly:
        i. Attempt to obtain a copy of the charges laid against the registrant;

ii. Ascertain whether there are search warrants or other public documents from the court docket available in relation to the charges and, if so, attempt to obtain copies of those documents;
iii. Determine the practice location(s) of the registrant, including whether the registrant has privileges at any facility;
iv. Where possible, ascertain whether the person reporting to CPSM has also made a report to each facility where the registrant has privileges and, if so, the content of that report and to whom the report was made.

c. Where a registrant who has been charged with a serious criminal offence is a member of the medical staff of a regional health authority, the Registrar must promptly communicate with the Chief Medical Officer of that regional health authority to ensure that the Chief Medical Officer is aware of the charges against the registrant.
d. Where a registrant who has been charged with a serious criminal offence is not a member of the medical staff of a regional health authority, the Registrar must promptly notify the Deputy Minister of Health of the charges against the registrant.
e. Where CPSM has obtained copies of charges or other documents from the court docket respecting the charges against a registrant, the Registrar must provide copies of these documents to the Chief Medical Officer or the Deputy Minister of Health as the case may be.
f. In accordance with *The Regulated Health Professions Act*, the Investigation Chair is responsible for determining whether a registrant who is charged with a serious criminal offence:
i. should be allowed to continue to practice without restriction,
ii. should be interim suspended from practice,
iii. should be allowed to practice subject to the imposition of interim terms and conditions, or
iv. should be allowed to practice subject to the terms of an undertaking
g. Where the Investigation Chair is contemplating allowing the individual to practice subject to the terms of an undertaking, the Investigation Chair must assess whether:
i. the public can only be adequately protected by an undertaking that authorizes CPSM to provide any and all information respecting the criminal charges against the registrant to the Chief Medical Officer of any regional health authority where the registrant has privileges or to the Deputy Minister of Health, as the case may be.
ii. the public can only be adequately protected by the imposition of terms and conditions which are a matter of public record.
h. Where the report to CPSM is made by the police, the Registrar must confirm with the police that CPSM will disclose the information provided by the police to Chief Medical Officer of any regional health authority, and if applicable CancerCare, Diagnostic Services of Manitoba, or Shared Health Services of Manitoba, where the registrant has privileges or to the Deputy Minister of Health, as the case may be.

Posting criminal conviction on Practitioner Profile

98. The Registrar must use the following criteria to assess whether a Registrant's criminal conviction is relevant to the registrant's competence or safe practice of medicine:
    a. The conviction is based upon an event that resulted from a physician/patient relationship, and/or
    b. The conviction results from harm to a patient or society related to or resulting from the practice of medicine, and/or
    c. The conviction indicates that the registrant's ability to practise medicine safely is compromised taking into account the following factors:
        - the nature of the offence;
        - any prior convictions;
        - the length of time since the conviction;
        - the completion of any penalty imposed;
        - the degree of regret and remediation demonstrated by the registrant;
        - the potential that the offence will affect the registrant's current practice.

99. Where the Registrar is of the opinion that a Registrant's conviction is deemed relevant to the Registrant's competence or to the safe practise of medicine, the Registrar must inform the registrant that the registrant's conviction will be published on the practitioner profile within thirty days. The notification must be in writing and must include the reasons for the decision.

100. The registrant may appeal the decision to post their criminal conviction to the Executive Committee within 30 days of being so notified. The appeal must be in writing and must state the reasons for the appeal.

101. The Executive Committee shall notify the registrant of its decision in writing.

102. The conviction shall be posted pending the appeal decision of the Executive Committee.

PART I – COMMUNICATION WITH CPSM

Registrant's Response to CPSM Correspondence

103. When the Registrar, an Assistant Registrar or a Medical Consultant engaged by CPSM writes to a registrant with respect to any matter and requires a response, the registrant shall:
    a. respond in writing;
    b. when responding to correspondence related to a complaint or investigation, unless otherwise approved by the CPSM Medical Consultant, personally sign the response. In respect to all other correspondence, electronic signature of the registrant will suffice unless otherwise directed by the Registrar, Assistant Registrar or Medical Consultant.
    c. provide a response to the substance of the matter, and all particulars pertinent thereto; and
    d. respond within the length of time specified in CPSM correspondence.

Reminder

104. When reminder correspondence is sent to a registrant from the Registrar, an Assistant Registrar or a Medical Consultant engaged by CPSM and the registrant fails to respond in writing within 15 days from the date of the reminder correspondence, the registrant may be referred to the Investigation Committee.

Compliance

105. A registrant who, without a reasonable excuse, fails to comply with section 103 or 104 may be found guilty of professional misconduct.

106. Except for correspondence sent requiring a registrant to respond in less than 5 days, correspondence sent to a registrant may be sent by ordinary mail addressed to the registrant's business address as appears on the records of CPSM. A correspondence sent by ordinary mail to a registrant shall be deemed to be received by the registrant on the fifth working day after the date of the correspondence.

107. In the absence of specific instruction to the contrary, CPSM shall regard each registrant's primary practice location as that registrant's business address.

Business Address

108. Correspondence being mailed to a registrant will be sent to that registrant's primary practice location unless the registrant provides to CPSM an alternate address as the address for all official notifications.

PART J - MEDICAL CORPORATIONS

Change in information

109. A medical corporation must inform the Registrar, in writing, of any change in the shareholders, directors or officers of the medical corporation within 15 days of such change.

PART K – ELECTION TRANSITION

Election Transition

110. In 2020, the following elections of regulated registrants will be held:

East Electoral District	– one Councillor for a two-year term;
West Electoral District	– one Councillor for a four-year term;
Winnipeg Electoral District	– three Councillors for a four-year term.

111. In 2022, elections of regulated registrants will be held according to the schedule set out in Part B of this Affairs of the College Bylaw and the Code of Ethics of CPSM. Section 6 (Election Transition) shall continue in effect only until January 1, 2022.

PART L - REPEAL

Repeal

112. Bylaws No. 1, 2, 3, 3D, 4, 5, 6, 7, 8, 9, 10 and 11 of the CPSM previously enacted by Council, pursuant to *The Medical Act*, with all amendments thereto, are repealed effective January 1, 2019. This Bylaw shall be in force as of and from January 1, 2019. This Bylaw has not retroactive effect and the previous bylaws now repealed, maintain authority for the period in which they were in effect.

PART M – BOARD OF ASSESSORS

113. The Board of Assessors is established in accordance with section 31 of the RHPA to consider and decide on applications for registration under section 32 or 33 upon referral by the Registrar.

114. Terms of reference for the Board of Assessors are set out in the Governance Policy of Council, and include the Board's authority, purpose, composition, and the term of office for Board members. The Board of Assessors is required to operate within the terms of reference established from time to time by Council.

115. Members of the Board of Assessors shall be paid remuneration and travel expenses at such rates and in accordance with the Financial Management Policy of Council.

PART N - SCHEDULES

ELECTORAL DISTRICTS - SCHEDULE "A" TO THIS BYLAW

Electoral Districts

Winnipeg Electoral District: That area within the boundaries of the City of Winnipeg and the Rural Municipalities of West St. Paul and East St. Paul.

Rural Electoral District: That area of the province not included in the Winnipeg Electoral District.

PROCEDURAL RULES FOR THE INQUIRY COMMITTEE – SCHEDULE "B" TO THIS BYLAW

Meeting to Set Hearing Dates

1. Upon referral of a matter to the Inquiry Committee pursuant to s. 102(1) of the RHPA, the Registrar shall give written notice to the investigated registrant of the date on which the chair or vice-chair of the Inquiry Committee will hold a meeting for the purpose of setting a date for convening and conducting a hearing in accordance with the requirements of s. 116 of the RHPA.

2. Neither the investigated registrant nor CPSM are required to appear in person for any meeting for the purpose described in section 1 herein where the chair or vice-chair of the Inquiry Committee is provided with sufficient information from legal counsel for CPSM and the investigated registrant or the registrant's legal counsel in advance of the meeting for the purpose of:
   a. setting the date(s) for beginning and conducting the hearing; and
   b. selecting a panel of the Inquiry Committee which will hold the hearing.

3. In order to comply with the requirements of s. 116 of the RHPA:
   a. the date on which the hearing begins must be within 120 days of the matter is referred to the Inquiry Committee by the Investigation Committee unless the investigated registrant consents in writing to a later date; and
   b. allow for the Registrar to give written notice to the investigated registrant and the complainant stating the date, time and place of the hearing, and identifying in general terms the complaint or matter about which the hearing will be held at least 30 days before the hearing begins.

Pre-Hearing Conference

4. The chair or vice-chair of the Inquiry Committee or any other person who is a member of the Inquiry Committee and is appointed by the chair or vice-chair of the Inquiry Committee may order a pre-hearing conference at any time before the hearing begins at the request of the investigated registrant or the registrant's legal counsel or legal counsel for CPSM or on the chair or vice-chair's own initiative.

5. The pre-hearing conference may be conducted by the chair or vice-chair of the Inquiry Committee or their appointee or by legal counsel to the Inquiry Committee.

6. Legal counsel for CPSM and the investigated registrant or the investigated registrant's legal counsel must participate in any pre-hearing conference ordered pursuant to this bylaw.

7. The pre-hearing conference may be conducted in person, or by video, telephone conference, web casting, or an equivalent mechanism provided that all parties participating are able to communicate with each other.

8. A pre-hearing conference may address any number of matters, including the following:
   a. the identification and simplification of the issues;
   b. the necessity or desirability of amendments to the Notice of Inquiry;
   c. the possibility of obtaining admissions which might facilitate the hearing;
   d. the discovery and production of documents;
   e. the estimated duration of the hearing;
   f. whether any preliminary motions are anticipated and the need to file a motions brief in respect of same; and
   g. any other matters that may aid in the disposition of the Notice of Inquiry.

9. The person conducting the pre-hearing conference may adjourn the pre-hearing conference to a specified date, time and place.

10. Agreements and/or undertakings made at a pre-hearing conference may be recorded in a memorandum prepared by or at the direction of the person conducting the pre-hearing conference. Copies of the memorandum shall be provided to CPSM and the investigated registrant.

Appointment of Registrants of the Panel

11. The person who conducts any pre-hearing conference(s) will not be appointed as a member of the Inquiry Panel hearing the matter unless the investigated registrant or the registrant's legal counsel or legal counsel for CPSM all consent to that person's appointment to the Inquiry Panel.

12. After the chair or vice-chair of the Inquiry Committee makes a preliminary selection of Panel members, both counsel for CPSM and the investigated registrant will be notified of the selection and provided with an opportunity to object to any Panel member selected. If there are any objection(s), they must be communicated in writing and include the reason(s) for the objection(s) such that a determination can be made as to whether any selected member(s) should be disqualified from serving as a Panel member

13. The chair or vice-chair of the Inquiry Committee will decide if a potential Panel member should be disqualified and will provide written reasons for the decision to both CPSM and the investigated registrant.

14. If either CPSM or the investigated registrant objects to the decision of the chair or vice-chair not to disqualify a panel member for any reason, the objection shall be dealt with by a formal motion unless otherwise agreed by CPSM and the investigated registrant.

Notice to Attend and Produce Records

15. Where either legal counsel for CPSM or the investigated registrant or the registrant's legal counsel makes a request, in writing, the Registrar may issue a Notice to Attend and Produce Records with the names of any number of witnesses which legal counsel for CPSM or the investigated registrant or the registrant's legal counsel identifies in the request pursuant to section 119(5) of the RHPA.

Alternative means of receiving Oral Evidence

16. Upon the motion of either CPSM or the investigated registrant prior to or during the hearing and with the consent of the Inquiry Panel, a witness may give evidence in person, or by video, telephone conference, web casting, or an equivalent mechanism.

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR DISCUSSION BRIEFING NOTE

SUBJECT: Prescribing Opioids and Prescribing Benzodiazepines and Z-Drugs Working Group Update

BACKGROUND:

The Working Group led by Dr. Charles Penner has met on 6 occasions, the most recent being September 16, 2026. The drafting of a proposed Standard of Practice is nearing completion. The working draft considered by the Working Group for its consideration on September 16, 2026 will be provided confidentially for discussion.

The Working Group has:

- Developed a terms of reference
- Prepared a work plan
- Conducted separate online surveys of registrants (240 responses) and pharmacists (48 responses)
- Performed a jurisdictional scan of other provincial MRA's standards of practice
- Reviewed a presentation on the 2025 Manitoba Prescription Opioid Atlas
- Reviewed data related to Benzodiazepine and Z-hypnotics use, the risks and benefits

The current Standard of Practice – Prescribing Opioids is 9 pages in length, and the Standard of Practice – Prescribing Benzodiazepines & Z-Drugs is 4 pages in length with 12 pages of contextual information documents.

The goal of the Working Group is to combine the two standards into one document less than 5 pages in length that sets out the Core Principles of "Duty of Care", "Knowledge and Competency", "Good Medical Care", as well as "Core Components of Care and Medical Record Keeping", and how to respond when "Principles Colliding with Real World Realities".

Work on Contextual Information documentation will commence when the draft standard is finalized.

For Information Briefing Note prepared by: Mr. Mike Triggs, General Counsel

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Registrar/CEO's Report

Internal - People and Culture

- An Extended Leadership Team was formed, composed of program and department leaders. This will ensure mid-level representation is part of important internal decision-making and processes. The Extended Leadership Team has started meeting with the senior leadership team quarterly.
- Members of the senior leadership team took media training to satisfy the requirement in CPSM's internal media policy, which states that designated spokespeople must have training to be responsive to inquiries from the media.

External Relations

National & International regulatory engagements

- Participated in the Federation of Medical Regulatory Authorities (FMRAC) of Canada Round Table.
- Participated in the FMRAC Canadian Medical Mobility Register steering committee meeting.
- Participated in pre-meetings with the FMRAC executive director for the September FMRAC board meeting.
- Participated in the Medical Council of Canada Governance and Nominating Committee meeting.
- Attended the International Health Professions Education Conference.
- Co-presented a Coalition for Physician Enhancement webinar, *Physician Remediation: Setting the Stage for Improved Performance.*

Provincial Engagements

- Meets regularly with Silvester Komlodi, Deputy Minister of Health, Seniors, and Long-Term Care.
- Attended multiple Provincial Practice-Ready Assessment Stakeholders meetings.
- Participated in the Max Rady College of Medicine's Inaugural Day Exercises and White Coat Ceremony held at the Centennial Concert Hall on August 19. Brought greetings to the class of 2030 on behalf of CPSM and participated as a cloaker, welcoming 137 new medical learners.

- Met with a group of registrants to develop advice to the profession on the use of point-of-care ultrasound.
- Met with two different registrant groups regarding 1) the development of mandatory education focused on 2SLGBTQIA+ health and 2) supporting gender-affirming care.
- Delivered the introduction to self-regulation at the August cohort of the CPSM - Orientation and Introduction to the Manitoba Practice Environment.
- Participated in the Provincial Specialty Lead Meeting.
- Met with the Manitoba Government regarding the Mental Health Act amendments.
- Delivers monthly virtual Registration Orientation to all new CPSM registrants.
- Co-presented with Tara Myran, Restorative Practices Program director at the University of Winnipeg's Truth and Reconciliation Week.
- Attended the AI in Regulation conference in Winnipeg.

Addressing anti-Indigenous racism in medical care

- Attended the Indigenous Reconciliation Gathering at the Canadian Forces Base in Winnipeg with Tara Myran, Restorative Practices program director.
- Met with the Sagkeeng Anicinabe Nation Chief and leadership about the Restorative Practices Program and CPSM's commitment to addressing anti-Indigenous racism, in Fort Alexander – Sagkeeng First Nation.
- Did an interview, along with Tara Myran, on CJOB about the Restorative Practices Program's first anniversary.
- Participated in the Indigenous Advisory Circle meeting. At this meeting, the group discussed and decided to update its name to the *First Nations, Inuit, and Métis Advisory Circle*.

For Information Briefing Note prepared by: Dr. Ainslie Mihalchuk, Registrar & CEO

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Performance Metrics – 1stth Quarter Update

BACKGROUND:

The 2026-27 – 1st quarter performance metrics reporting scorecard is attached ***(Appendix A)*** for Council's review. The 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.

Several metrics have been modified or replaced after undergoing a review by the respective departments. See chart below for the changes by department.

The graphic on the attached scorecard highlights the following for each metric.

- a description of the performance indicator,
- the target(s) and where performance is not meeting the target,
- the variance explanation/course correction details.

For Information Briefing Note prepared by: Mr. Paul Penner, Chief Financial Officer

Metrics Updates/Changes by Department

Department	Program	2025-26 Metric	2026-27 Metric
Quality	Audits & Monitoring	Chart Reviews will be performed in a timely and predictable manner – Target was; 80% of reviews will be completed within 30 days of initial letter.	Target has changed to- 90% of completed reviews will be sent to the Registrant within 10 days of completion.
Quality	Physician Health	New	Ensure referrals are connected withing the appropriate time frame
Quality	Quality Improvement	QI process will be completed within targeted timelines for Categories 1, 2 & 3	QI has stopped tracking timelines for Category 3
Quality	PPP		Minor changes made
Quality	Restorative Practices	NA	New metrics added for this new program
Quality	Accreditation	Temporary status site metric and implementation of new WCAA Laboratory and Transfusion medicine standards roll-out both deleted	Metrics break out targets by Diagnostic Inspections (Public), Private Diagnostics, & Non-Hospital Medical Surgical Facility Inspections, with targets for each.
Complaints & Investigations		NA	4 new metrics to be reported on for 2026-27
Corporate	People and Culture	Employee satisfaction and engagement with CPSM priorities	Staff Development and Engagement Opportunities
Corporate	People and Culture	Staff Attendance	The staff attendance metric is being replaced with a more accurate number that depicts staff availability

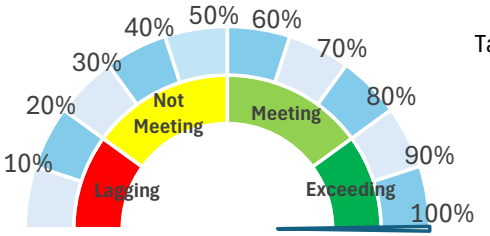
Corporate	Communications	Increase positive sentiment score in media coverage	Maintain positive sentiment in media coverage
Corporate	Communications	# of Educational opportunities executed	Increase Awareness of CPSM's regulatory role
Corporate	Communications	# of Engagement targets met	Creating engagement opportunities for Registrants

CPSM Performance Scorecard

2026-27 1st Quarter

	Snapshot				
	Quality	**CI**	**Registration**	**Support**	**Total**
Meeting/Exceeding	7	1	2	9	19
Not Meeting	1			2	3
Lagging	3				3
Insufficient data	8	3		1	12
Total # of Performance Metrics	19	4	2	12	37

QUALITY -Quality Assurance



Target

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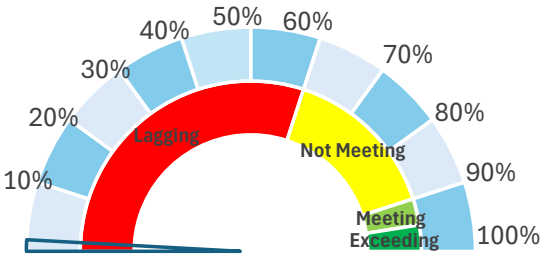

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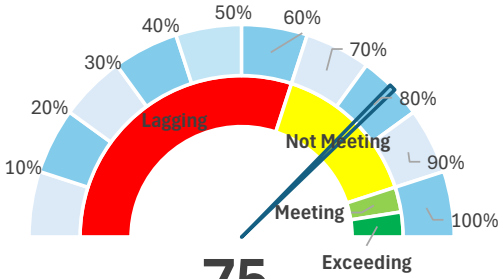

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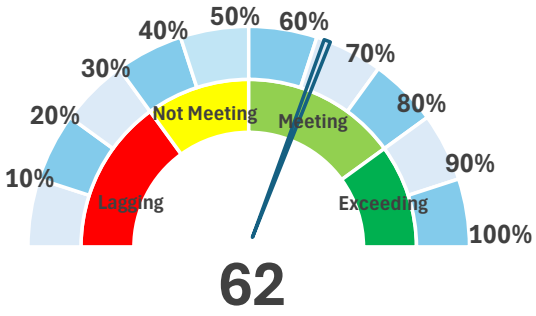
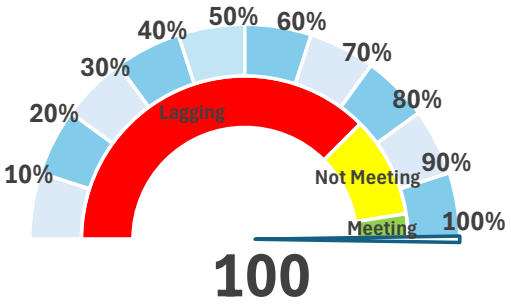
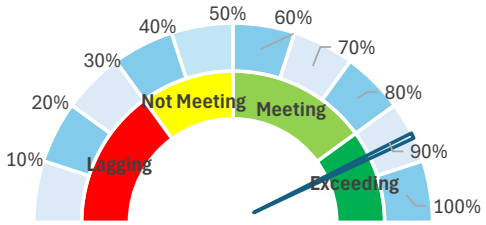
Performance Indicator	Registrants will demonstrate a measurable improvement on follow-up assessments	Chart Reviews will be performed in a timely and predicatable manner	Provisional Registration chart reviews will be sent to the physician in a timely and predictable manner
Targets	Target is 50%	Target is 90% - completed reviews will be sent to registrant in 10 days	Target is 90% - completed reviews will be sent to registrant in 10 days
Variance Explanation/Course Correction		New metric - currently gathering data	Volume of reviews has increased significantly with increased provisional registrants. We have redistributed workflows to accommodate increased volume and anticipate meeting target going forward.

QUALITY - Physician Health Program





Performance Indicator	# of referrals coming from registrants about self or others (self reporting)	Implement the necessary monitoring/restrictions on identified high-risk registrants.	PHP will survey registrants and other PHP participants to ensure registrants are feeling supported by the PHP and possibly identify opportunities for program improvement.
Targets	50% generated from self referrals	100% of flagged registrants are monitored	80% of surveyed registrants indicate that they had a neutral, positive, supportive or very supportive interaction with the PHP.
Variance Explanation/Course Correction			Will report annually only



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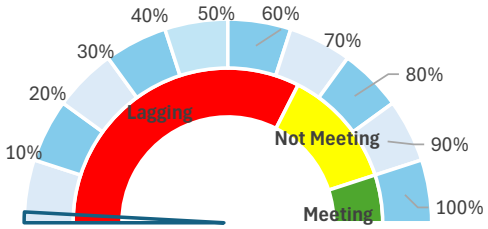
Performance Indicator	Ensure Referrals are connected to within the appropriate timeframe
Targets	2 days for sensitive referrals (85% target) & 5 business days for non-urgent (85%)
Variance Explanation/Course Correction	

QUALITY - Quality Improvement

Quality Improvement initiated 85% of eligible registrants



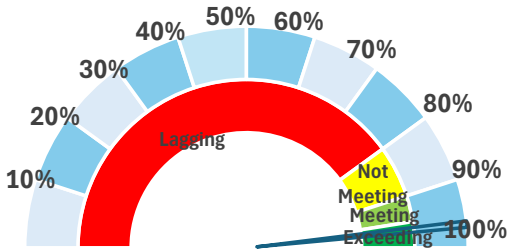
Spring cohort initiatied in August 2026
No data to report at this time

Category 1

Performance Indicator	CPSM will initiate reviews of 95% of all eligible registrants by the end of the seven year cycle (December 2025)
Targets	Initiate remaining eligible registrants
Variance Explanation/Course Correction	

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

QUALITY - Prescribing Practices Program



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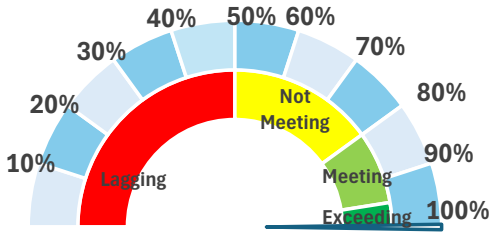

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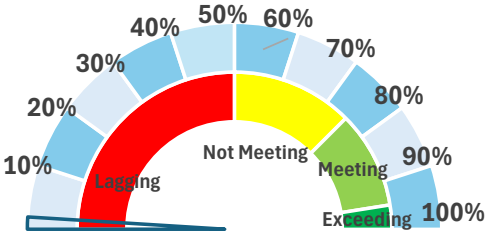


NA

100% high risk within 1-2 business days
90% moderate risk within 1-2 weeks

Performance Indicator	Will respond in a timely manner to general prescribing advice inquiries	PPP will provide timely intervention for general prescribing advice inquiries with significant risks identified	PPP will survey registrants who seek prescribing advice to identify opportunites for program changes/growth
Targets	90% - 5 business days	100% of high risk cases responded to in 1-2 business days 90% of moderate risk in 1-2 weeks	
Variance Explanation/Course Correction			

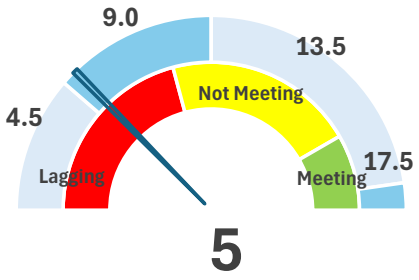
QUALITY - Restorative Practices Program

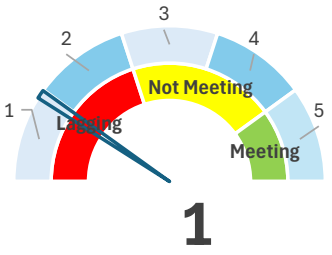
Data reporting is targeted to begin in the 2nd Quarter of 2026-27

Performance Indicator	Will respond in a timely manner to inquiries and referrals	Will hold Registrants accountable for upholding the Standard of Practice- Practicing Medicine to Eliminate Anti-Indigenous Racism	RPP will survey registrants, patients & communities
Targets	100% - 1 business days with 90% receiving engagement packages withing 10 business days	100% of engagement rate 75% will positively engage	75% target rate that respondants will feel supported
Variance Explanation/Course Correction			

Performance Indicator	**RPP will engage directly with Indigenous communities and organizations**
Targets	1 engagement per region per year Targeting a 30% increase in referrals from patients & communities
Variance Explanation/Course Correction	

QUALITY - Accreditation





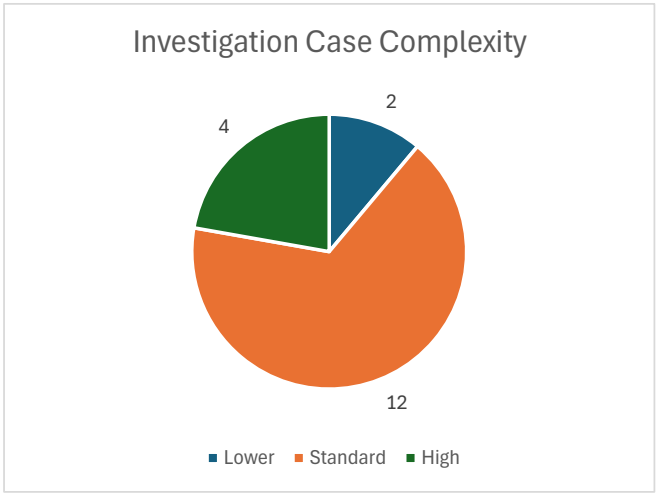
Performance Indicator	MANQAP will inspect the required number of facilities to be in compliance with the Manitoba Health contract	MANQAP will perform the required # of Private Diagnostic inspections	MANQAP will perform the required # Non-Hospital Medical Surgical Inspections required
Targets	70 Inspections Annually	14 Inspections/annum	Inspect 20 sites in 2026-27
Variance Explanation/Course Correction	Metric is the targetted number of inspections per quarter to reach the 70 target by year-end. Staffing shortages have impacted the number of inspections this quarter.	Due to staffing issues, 1st quarter is lagging. Expect to meet the target by year-end.	Staffing Shortages have impacted the number of inspections that should have occurred this quarter. Metric is the quarterly target.

COMPLAINTS & INVESTIGATIONS

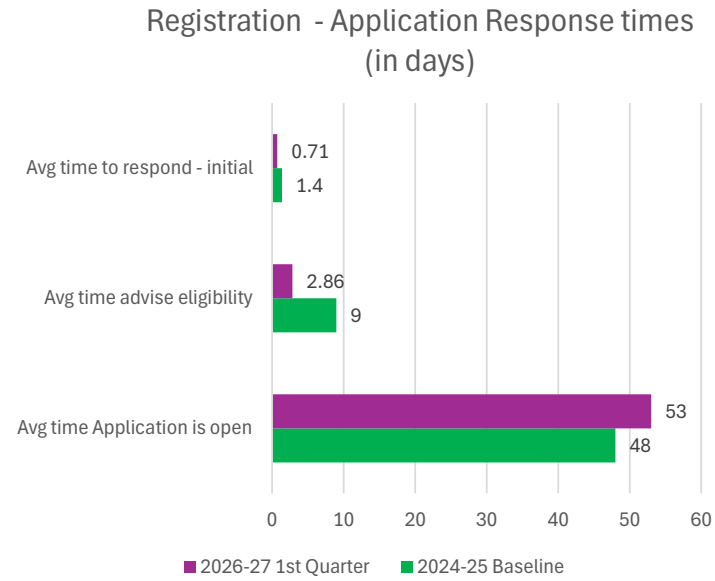
Intake to Triage -96 Days
Time to Triage - 9 days

Performance Indicator	Response Time for Boundary Violations/Severe Care Issues	Measuring operational process time from intake to Triage
Targets	Response plan is developed in 2 business days	Establishing Baseline
Variance Explanation/Course Correction	3 cases received and all had plans developed in under 2 business days	Overall time-to-triage: 96 days Time to triage once file complete: 9 days * measure is based on a sampling frame, pending rebuild of analytics area of the portal * 50% of delay related to obtaining records; 25% related to clarifications with complainant * Cases that are triaged straight investigations after preliminary review are excluded, since they do not go through significant analysis

Performance Indicator	Monitoring Proram compliance	Investigations will be classified by complexity
Targets	Will be measuring # of compliance visits with compliance rates	Classifying investigations to appropriately index timeliness of intervention
Variance Explanation/Course Correction	Gathering data, will report in 2nd quarter	18 Investigations launched since introduction of complexity measure

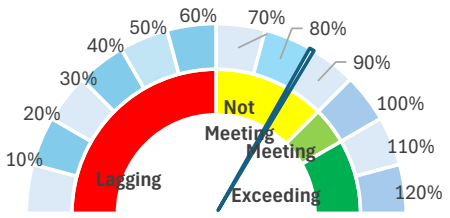


REGISTRATION



Performance Indicator	New metric under development	Compliance with Fair Registration Practices Office	Applications processed in a timely way.
Targets		Ensure adoption/compliance and timely reporting	Baseline (green bar) is from 2024-25 and relfects response time for 1,415 applications received
Variance Explanation/Course Correction			Baseline is 2024-25 for three categories *Avg time to respond to applicant - initial *Avg time to advise re eligibility *Avg # of days applications are "open"

SUPPORT AREAS - Finance



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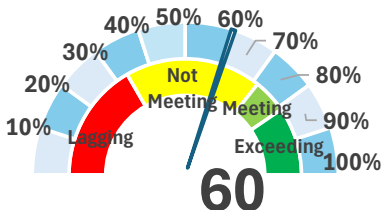
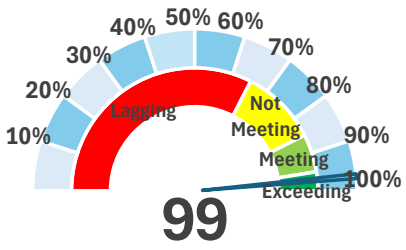
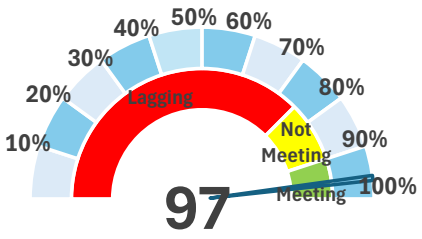
Performance Indicator	CPSM will maintain adequate reserves	CPSM will achieve a balanced budget	CPSM implement an investment strategy that supports it's mandate
Targets	Debt to Equity ratio of < 1.0 (reported annually). Reserves are maintained at a min 100% of operating expenses		Achieve a annual rate of return on investments of 8%
Variance Explanation/Course Correction	Debt to equity ratio .43 Reserves at 80% of operating expenses excluding government programs	1st Quarter results - $742,000 surplus	

SUPPORT AREAS - Information Technology

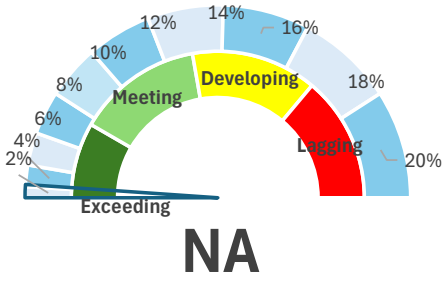






Performance Indicator	CPSM's technology and information is protected from both external and internal loss/destruction	Information Systems are considered highly reliable and available	IT responsiveness
Targets	Centre for Internet score of 70-75%	Target is 99%	Triage IT issues - 95% within 24 hours
Variance Explanation/Course Correction	Timing of the following implementations impacted the score Outstanding items: 1. Programming Review 2. Implementation of Data sensitivity labels 3. Disaster Table-top exercises - Cyber Breach. We expect to reach 65% by the fall of 2026		

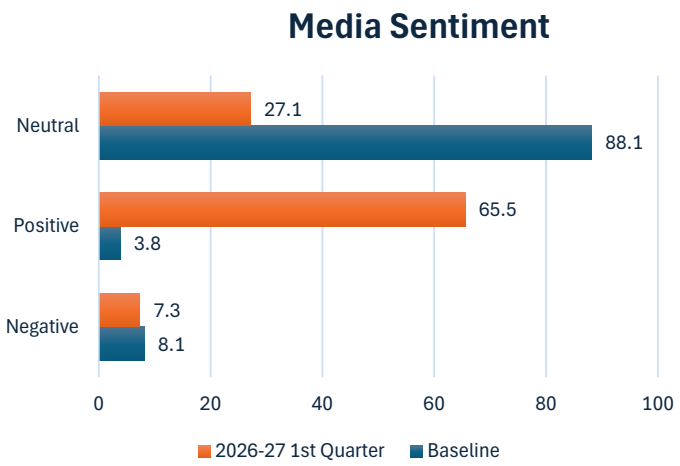
SUPPORT AREAS - People & Culture



NA

Performance Indicator	Staff are engaged and are provided with development opportunities	Retention of staff	Staff Attendance - staff are available to deliver on the goals of CPSM
Targets	Provide min of 1 development opportunity per quarter - 80% attendance	Turn over rate <10%	<4% Absence Rate
Variance Explanation/Course Correction	New Metric - currently gathering data	Reported Annually	January to July 2026 saw a 3.6% absence rate

SUPPORT AREAS - Communications



Performance Indicator	Maintain a positive sentiment score in media coverage	Increase the Awareness of CPSM's regulatory role	Creation of engagement opportunities for Registrants
Targets	Maintain postive sentiement	Educate the public on CPSM's role to	Boost engagement from the public & registrants
Variance Explanation/Course Correction	Baseline from 2025-26 Sentiment scores as of 4th quarter of previous year: Negative - 3.6% Positive - 49.6% Neutral - 46.8%	Public awareness topics and resources distibuted this quarter: 1) Patient rights and medical records 2) Practitioner Profile Search 3) What is a public consultation? 4) What disciplinary decisions does CPSM publish? Communications supported public awareness of the Restorative Practices Program by overseeing the design of the program's new logo, establishing standards for use, drafting conference abstracts, presentations, and copy for collateral. Co-planned a water ceremony to reaffirm CPSM's commitment to taking action on anti-Indigenous racism in medical care.	Launched four public consultations: 1) Amendments to General Regulation for Approved Jurisdiction Pathway 2) Amendments for Provisional registration of Family medicine registrants 3) Amendments to the Accredited Facilities Bylaw 4) Amendments to The Affairs of the College Bylaw Engaged a group of registrants on advice to the profession.

COUNCIL MEETING
JUNE 24, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Operational Reports

COMMUNICATIONS & MEDIA

Communications oversees corporate communications, including email campaigns, registrant, public, and media communications, as well as launching new or updated Standards of Practice, conducting public consultations, and developing assets to support communications campaigns. Priorities and recent work completed in this quarter include:

- Executing the development and public release of the **2025-26 annual report**, including a media release and managing related news coverage.
- Managing the production of a video on the significance of anti-Indigenous racism and how CPSM is responding to the Truth and Reconciliation Commission 94 Calls to Action.
- Communications following the launch of the Standard of Practice – Collaborative Care.
- Launched four public consultations, giving interest-holders opportunities to share feedback on proposed regulatory changes:
    - Amendments to CPSM General Regulation for approved jurisdiction pathway
    - Amendments for Provisional registration of family medicine registrants
    - Amendments to The Accredited Facilities Bylaw
    - Amendments to The Affairs of the College Bylaw
- Met with executive director and board member of Community Living Manitoba to explore address the lived experiences persons with intellectual disabilities and/or persons with autism face when seeking medical care, in a series of articles to be shared with the profession.
- Was part of a group drafting advice to the profession on the use of point-of-care ultrasound, which included registrants.
- Wrote More Than a Title: Why recognition matters for IMGs in Manitoba for Rounds (Doctors Manitoba publication) which was published in their Summer 2026 edition.
- Supported the Registrar's office with external communications and presentation materials.
- Responded to media inquiries on regulatory matters. Media coverage in this period included:
    - An inquiry panel disciplinary decision against a registrant (Winnipeg Free Press, CBC Manitoba, CTV News Winnipeg, CityNews Winnipeg).

    - Promoting awareness of the Restorative Practices Program (CJOB).
- Coordinated media training for CPSM-authorized spokespeople to satisfy internal media policy requirement that CPSM have senior leaders are trained to respond to media.
- Updated metrics to better measure public awareness and registrant engagement activities.
- Co-hosted internal AI Forum for staff.
- Attended AI in Regulation conference in Winnipeg.
- The Director of Communications was selected to present at the Canadian Network of Agencies for Regulation Conference in October.

Supporting the Restorative Practices Program

Working closely with the Restorative Practices Program (RPP) team to execute its communications plan for the program and the mandatory cultural safety and anti-Indigenous racism training for registrants. Work completed this quarter includes:

- Overseeing the design of the program's new logo and establishing standards for use.
- Drafting conference abstracts, presentations, and copy for program collateral and website.
- Co-planned a water ceremony to celebrate the one-year anniversary of the Restorative Practices Program and to reaffirm CPSM's commitment to ensuring the program operates in a meaningful way, is Indigenous-led, and is guided by Indigenous philosophies and in consultation with First Nations, Inuit and Métis people.

Public awareness topics and resources distributed this quarter:

1. Patient rights and medical records
2. Practitioner Profile Search
3. What is a public consultation?
4. What disciplinary decisions does CPSM publish?

Registrant communication campaigns:

- Launch of the Standard of Practice - Collaborative Care.
- AGM update and June Council meeting update.
- June newsletter – topics included: Timely completion of the disability tax credit certificate (form T2201), election results and introduction of new Council, members, position statement on inhalational sedation and analgesia, CancerCare Manitoba New Referral Guidelines, and Physician Office Lab inspection information and checklist.
- Public consultation notices.

Submitted by:
Wendy Elias-Gagnon
Director of Communications

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The Complaints and Investigations Department has completed its first year since the departmental transformation in September 2025 and has completed approximately six months under the whole suite of new processes. Overall, the department has achieved and is maintaining a pace of opening and closing investigations at parity, so that the number of investigations being closed matches the number being opened. This is the result of improved process efficiency, incredible staff dedication and committed Investigation Committee members. Having achieved sustainability over time, we can now dedicate surge resources to tackle the backlog of cases that predate the September 2025 transformation. Given the relative rarity of investigation skill sets, we are looking at a variety of novel skills sets to complement existing staff strengths.

Another significant milestone was the rollout of a completely revised and updated procedure manual on September 2, 2026. This manual is based on a complete review of all existing procedures, which have been reviewed and updated to match our new processes and address previously identified gaps. This manual will make departmental operations easier and facilitate upcoming and future onboarding efforts.

Fall activities will focus on recruitment, tackling the backlog of cases and completely revamping the C&I section of the website to bring it into line with the new procedure manual. Furthermore, dedicated efforts to ensuring plain language review and highlighting our accessibility tools more prominently will form a key aspect of the website review.

Submitted by:
Dr. Guillaume Poliquin
Assistant Registrar, Complaints & Investigations Department

FINANCE

1st Quarter Financial Results (2026-27)

CPSM posted a net surplus of $736,000 favorable variance. Favorable variances of $215,000 in revenues and $282,000 in expenditures in the core operations both played significant roles in producing favorable operating results for the period.

The main source of the revenue variance was Investment Revenue with a favorable variance of $123,000 due to solid performances by both the portfolio's bond and equity segments, especially

the latter. On the expense side, a favorable variance of $112,000 in salaries due to timing & various staff transitions were the primary contributors.

Investment Update

The composite return on the investment portfolio was 3.1% for the entire quarter. In comparison, the forecast for the whole year is 3.6%. The combination of favorable equity market and increased equity investment exposure continue to deliver for the investments, with a portfolio mix hovering around 60:40 equity-to-fixed income ratio.

Of the $6.0 million total investments, $1.7 million worth of GIC's will mature in the 2nd quarter. CPSM's investment advisor presented their reinvestment plan to the Finance, Audit, and Risk Management Committee showing continued implementation of the current investment strategy.

Submitted by:
Mr. Paul Penner
Chief Financial Officer &
Mr. Johnvee Calaguian | Controller

INFORMATION TECHNOLOGY

IT has been focused on improving user experience. Along with the upcoming renewal changes, which will make reporting issues simpler for physicians, our users will now be able to report and update any legal disclosures, any time throughout the year.

Non-Hospital Medical Surgical Facilities [NHMSF] now have presence in the CPSM Portal. Users are able to update important facility information. NHMSF renewals will start December 1, in the Portal.

With the assistance of MSP Corp, CPSM underwent a Cloud Transformation review. The intention is to move our infrastructure to the Cloud starting in 2027. This is a significant undertaking with the intention of reducing our local footprint and enhancing our cybersecurity posture.

Submitted by:
Mr. Sam Lount
Manager, Information Technology

PEOPLE AND CULTURE

People and Culture is responsible for developing and executing human resource strategies in support of the overall operational plan and strategic direction of CPSM. This includes talent

management, organizational and performance management, training and development, as well as total compensation. The position provides strategic leadership by articulating human resources needs and plans to the executive management team, strategic partners, and Council.

Work continues to assess and update roles and responsibilities within department structures.

An asynchronous course was assigned learning to all staff to introduce Psychological Safety – A Mindful Employee

Submitted by:
Ms. Sherry Dupuis
Executive Director, People and Culture

QUALITY DEPARTMENT

Manitoba Quality Assurance Program (MANQAP)

- Unexpected staff absences, three temporary and one permanent impacting workflow.
- Immediate resolution Dauphin pop up site for limited laboratory and portable imaging DI accredited.
- Thompson to Pas portable MRI unit accredited.
- Dauphin Hospital ER and DI reopening scheduled for Sept 7.
- Portal system for Non-Hospitals Medical and Surgical Facilities (NHMSF) early stages of being operational.
- Verbal approval for Government Funding to support Physician Office Laboratories program- 3-year commitment.
- Continued engagement and progress with Provincial Privileging Committee to assist with physician privileging and procedures within NHMSF.

Physician Health Program

- PHP survey has been implemented into the portal, smooth transition and new ease in tracking survey responses.
- Currently transitioning invoicing for monitoring charges to PHP from finance for management; will create a better system for tracking and provide more methods of payment available to registrants.
- Since the beginning of the fiscal year (May 1), we have had 40 new referrals with 3 requiring PHP undertakings, bringing the total number of current undertakings to 47.
- Current PHP caseload is 100 (this number is the total number of undertakings, any active/new cases, registrants requiring PHP follow-ups and any registrants on a medical LOA, reportable to CPSM, to be reviewed by PHP before return can be approved).
- Return-to-work post medical leave/health condition policy revision underway.

Prescribing Practices Program (PPP)

- Registrant Advice & Support: responded to 38 general prescribing advice inquires Jun-Aug.

- Outcome Evaluation: 33% response rate Jun-Aug for survey sent to registrants/HCPs who seek prescribing advice, to evaluate the impact of PPP intervention. Results reported at year-end for data analysis/significance.
- Prescribing Approvals: Issued 13 Suboxone & 3 methadone approvals for OAT Jun-Aug (current total 298 OAT prescribers). 1 pain/palliative methadone approval Jun-Aug (current total 77 P&P prescribers).
- Prescribing Rules: Supporting SLT with revision of SOPs for prescribing opioids and prescribing benzodiazepines/Z-drugs.
- High Dose Morphine Milligram Equivalents (MME) Reviews: Reviewing cases identified by MB Health DPIN dataset, involving high-dose opioid prescribing (≥ 900 MME per day). Case-based and audit/feedback intervention used to promote quality assurance and safer prescribing practices. 2026 reviewing 11 registrants (2025 reviewed 12 registrants).

Quality Assurance Program (QAP)

- New software improved function for creating and distributing Central Standards Committee agenda.
- Continuing increase in the number of registrants being monitored this year (PA, CA, Provisional Registrants and Recognized Training Route registrants). There are currently 185 active PAs and 240 active CAs. A total of 62 Provisional and RTRs chart reviews were completed from January 1, 2026 to September 1, 2026.
- Between January 1, 2026 and September 1, 2026 there were 36 additional referrals sent to the Quality Assurance Program for review.

Quality Improvement Program (QIP)

- Continued updates made to forms and Portal functions for second cycle.
- New staff member in administrative assistant position.

Restorative Practices Program (RPP)

- New metrics have been established for this reporting period.
- Total cases up to September 1 2026: 59.
- 24 remain open and 35 are closed.

Conferences:

- Abstract accepted for Tara Myran (TM) and Dr. Jayson Stoffman (JS) to facilitate a workshop at the National Restorative Justice Symposium in November 2026. Presentation title: “Maawanji’idiwag (We Come Together): Restorative Justice to build community in healthcare”.

Awareness Campaign and Outreach:

- June 2026:
    - Presented to Health, Outreach, and Community Support (HOCS), WRHA, at their Network Meeting (TM and Meaghan Cabel (MC)).
- July 2026:
    - Interview about RPP with CJOB Radio – Richard Cloutier (TM/Dr. Ainslie Mihalchuk (AM)).
    - Presented at a Lunch and Learn for the Portage Clinic in Portage La Prairie (TM/JS).
- August 2026:
    - Met with and presented to Sagkeeng Anicinabe Nation Chief and Leadership (TM/AM).
    - Filming Interview for Anti-Racism (TM).
    - Met with Life’s Journey Inc. (TM/MC).

- Ongoing:
    - RPP (TM/JS) continue to present at the International Medical Graduates Orientation at CPSM.
    - RPP (TM/JS) sit on the Postgraduate Medical Education Truth and Reconciliation Action Plan (PGME TRAP) Oversight Circle, Max Rady College of Medicine, University of Manitoba.
- Cultural Safety and Anti-Indigenous Racism Training: Website information and the downloadable information sheet is now updated with the two new pre-approved course options for registrants to fulfill the CSAIR Training requirement. Working closely with IT for CPSM Portal updates and with Registration and Communications.
- Logo and Branding: The RPP Logo, developed by Vincent Design (an Indigenous-led design agency) has been incorporated into updated RPP materials and a 1-pager information sheet developed by Communications.
- Restorative Justice Facilitation Training completed by Dr. Courtney Leary and Tara Myran.
- CPSM Media Training completed (TM/JS).

Submitted by:
Dr. Sonja Bruin
Assistant Registrar, Quality Department

REGISTRATION DEPARTMENT

With registrant numbers steadily increasing (see Annual Report), the Registration Department continues to manage a high volume of registration and licensing activity across multiple applicant streams. This includes newly developed registration and licensure pathways.

A particular operational focus has been the continued refinement of internal workflows and use of the registration portal. Work with IT remains central to improving data capture, reducing duplication, supporting more consistent processing, and developing the infrastructure needed for more reliable reporting and data analysis. These improvements are intended to support both service delivery and future performance measurements, including the Department's ongoing work toward key performance indicators, key risk indicators, and a more structured quality management approach.

Policy and regulatory work have continued to focus on clarifying registration pathways, improving accessibility of requirements, and aligning CPSM's approach with emerging national discussions on credential recognition, labour mobility, and registration modernization. Areas of ongoing work include:

- continued refinement of registration policies, including work to consolidate registration-related authorities into a clearer and more accessible source;
- further development of pathways and requirements for internationally trained physicians, including consideration of comparable jurisdictions, recognition frameworks, and assessment requirements;
- continued work related to Practice Ready Assessment programs, including eligibility, assessment processes, governance, and quality assurance;
- review of processes relating to clinical assistants and physician assistants, including registration requirements and the approval of contracts or arrangements for supervision; and
- continued work on registration renewal questions and related processes to ensure they support effective regulatory oversight while remaining clear and proportionate.

The above work is informed by the Department's engagement with Manitoba's Fair Registration Practices Office, other Canadian medical regulatory authorities, national certifying bodies, and provincial partners.

Several projects have progressed during this past quarter:

- Continued development of a data and reporting strategy to support evidence-based decision-making, operational planning, performance monitoring, and external reporting obligations.
- Ongoing improvement of the Registration section of the CPSM website, with a focus on clearer step-by-step information for applicants and registrants, particularly for more complex registration pathways.
- Continued support for Practice Ready Assessment development and improvement, including work connected to family medicine and emergency medicine pathways.
- Continued participation in cross-jurisdictional discussions concerning credential recognition, comparable jurisdictions, certification, licensure portability, and streamlined registration pathways.
- Ongoing work with provincial partners to improve communication and coordination for applicants entering Manitoba's physician workforce.
- Continued development and delivery of orientation initiatives for new registrants, with attention to regulatory expectations, standards of practice, professionalism, and system navigation.

Submitted by:
Mr. Jeremy de Jong
Director, Registration Department and Innovation

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Minister Appointed Public Roster

BACKGROUND:

On August 25, 2026, CPSM received correspondence from the Minister of Health, Seniors and Long-Term Care regarding new appointments, re-appointments and removals of members to the Public Roster from which CPSM Council appoints individuals to Committees.

The following is a current status of the Minister Appointed Public Roster.

The following individuals have been **appointed** to the College of Physicians and Surgeons of Manitoba Public Roster effective August 19, 2026, with an expiry date of August 18, 2029.

- Jude Uzonna
- Peter Chackowsky
- Michael Desautels

The following individuals have been **re-appointed** to the College of Physicians and Surgeons of Manitoba Public Roster effective August 19, 2026, with an expiry date of August 18, 2028. The CPSM Committees that they are currently on or most recently were on are listed in parentheses.

- Nicole Smith (formerly on Complaints Committee)
- Sylvester Oyamienlen (formerly on Complaints Committee)
- Alan Scramstad (Inquiry Committee)
- Cheryl Smith (Investigation Committee)
- Eileen Gelowitz (Program Review Committee)
- Elizabeth Tutiah (Investigation Committee)

The following individuals have been **removed** from the Public Roster:

- Diana Yelland (Inquiry Committee)
- Raymond Strike (Investigation Committee)
- David Bjornson (Inquiry Committee)

The following **continue** to be on the Public Roster:

- Ryan Gaudet (Inquiry Committee)
- Sandra Martin (Inquiry Committee)
- Leanne Matthes (Investigation Committee)
- Lynette Magnus
- Scott Greenlay (Inquiry Committee)

At the June 24, 2026 Council meeting, Michael Desautels, Libby Standil and Susan Boulter were appointed to the Inquiry Committee as public representatives conditional upon their appointment to the Public Roster. We are still awaiting approval confirmation for our request to add Ms. Standil and Ms. Boulter to the Public Roster.

For Information Briefing Note prepared by Mike Triggs, CPSM General Council

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Minister Appointed Public Representative on Council

BACKGROUND:

There are 6 public representatives appointed to CPSM Council, 3 are appointed by the Minister and 3 are appointed by CPSM.

Minister appointed public representatives:

- Mr. Allan Fineblit, KC
- Ms. Leanne Penny
- Vacant

CPSM appointed public representatives:

- Ms. Lynette Magnus (4-year term ends 2030)
- Mr. Neil Cohen (4-year term ends 2028)
- Ms. Leslie Agger (4-year term ends June 28, 2027)

Ms. Penny and Mr. Fineblit's term's end on December 1, 2024 and April 5, 2026 respectively but continue because the provision of their appointment is that they continue to hold office after their term expires until they are re-appointed or a successor is appointed.

The Minister's Office has been advised that the appointment previously held by Ms. Marvelle McPherson is vacant and an appointment is required.

For Information Briefing Note prepared by Mike Triggs, CPSM General Counsel.

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR DISCUSSION BRIEFING NOTE

SUBJECT: **Populations Identifying Gaps in Care**

BACKGROUND:

Manitoba is fortunate to have a very diverse population. A consequence of a diverse population is there are medical care issues unique to single population groups. In the past year, organizations representing various populations have approached CPSM with identified gaps in the care these populations have received.

A common request from these organizations is that CPSM create specific standards of practice for their populations. It is not practical or efficient for CPSM to create specific population-based standards of practice. The challenge arises for registrants when they are unaware of issues specific to an individual population group. For example, a communication style that is commonly used for one population group may unknowingly be offensive to another and this will negatively impact the care that person receives.

The purpose of this agenda item is to have an open discussion with Council on CPSMs approach for addressing gaps in care identified for specific population groups. A confidential draft communication plan for one of these identified population groups will be provided separately.

For Discussion Briefing Note was prepared by Mike Triggs, CPSM General Council

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Restorative Practice Program Presentation

BACKGROUND:

Members of the Restorative Practice Program will be providing Council with a presentation on the progress, successes and barriers of the program.

For Information Briefing Note was prepared by Ms. Helena Tessier, Executive Assistant to Corporate Council and Complaints and Investigation Department

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: September 24 CPSM All-Staff Orange Shirt Day

BACKGROUND:

Each year CPSM staff participate in events to honour Orange Shirt Day (September 30, 2026). Due to Orange Shirt Day being a provincial statutory holiday, the CPSM offices will be closed therefore, the following events will be held on September 24, 2026, with a light snack being provided of traditional Bannock and jam catered by Shelly's Indigenous Bistro The events will be facilitated by Ms. Tara Myran | Program Director & Knowledge Translation and Mobilization Specialist and Nookomis Debbie Cielen | Elder, Director, Senior Manager at Life's Journey Inc.

1. Optional Smudging and Water Blessing – 1:00-1:30 PM (Tara Myran and Nookomis Debbie Cielen)
    i. Opening drum song
    ii. Teaching of the Smudge Purification Ceremony
    iii. Smudging for staff (optional)
    iv. Water Blessing (honouring the Four Directions – all can participate)

2. Orange Shirt Day Presentation – 1:30-2:30 PM (Tara Myran and Nookomis Debbie Cielen)
    i. Opening Prayer
    ii. Orange Shirt Day Presentation
    iii. Two-Eyed Seeing Presentation
    iv. Questions and Comments from Staff
    v. Closing Prayer/Hand Drum Song

We are encouraging CPSM Council members to honour Orange Shirt Day on September 23 (Council meeting day) by wearing ***orange***. As well, traditional Indigenous food will be provided to CPSM Council during the lunch break, catering by The Feast.

For Information Briefing Note prepared by Ms. Barbie Rodrigues, Senior Executive Assistant to Registrar & CEO

COUNCIL MEETING
SEPTEMBER 23, 2026
NOTICE OF MOTION BRIEFING NOTE

SUBJECT: **Approved Jurisdictions Policy**

Purpose:

To seek approval for the new Council Policy – Approved Jurisdictions (see ***Appendix A***).

Background:

On September 9, 2026, Cabinet approved amendments to the *CPSM General Regulation* establishing a pathway that permits eligible physicians from approved international jurisdictions to obtain registration based on their qualifications for independent practice and completion of substantively equivalent postgraduate training programs. The amendments contemplate that Council will determine which jurisdictions are approved.

The attached policy is a list of proposed approved jurisdictions. The process for determining how jurisdictions were identified for this list is outlined below. This process is "Phase 1" for identifying jurisdictions. "Phase 2" is also explained below, but implementation is subject to further development of an approval rubric and/or the enactment of further regulatory amendments.

Phase 1

Phase 1 focuses on jurisdictions that have already undergone substantial review and approval by Canadian medical organizations and MRAs. Specifically, it is proposed that Council begin by considering jurisdictions that meet the following criteria:

1. The jurisdiction is already recognized by a Canadian national medical certifying body, namely the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada, as having training and certification systems that may lead to eligibility for Canadian certification; and
2. The jurisdiction has already been recognized by multiple Canadian MRAs for direct or substantially expedited licensure pathways. In essence, this means physicians registered in these jurisdictions for unrestricted and independent practice would be able to become licensed in Manitoba via labour mobility provisions.

This approach allows CPSM to leverage work already undertaken by national certifying organizations and fellow Canadian MRAs rather than creating an entirely new assessment framework from first principles.

Policy support for this approach:

1. Canadian certifying organizations have already conducted reviews of international postgraduate medical education and certification systems when determining eligibility routes for certification. Similarly, several Canadian MRAs have completed assessments of international jurisdictions for licensure purposes. Building upon these reviews would reduce duplication and improve consistency.
2. Adopting jurisdictions already recognized elsewhere in Canada would promote greater alignment among Canadian MRAs and reduce unnecessary barriers to physician mobility and recruitment. It would also increase predictability for applicants seeking registration in Manitoba.
3. Prioritizing jurisdictions already assessed by trusted organizations will permit CPSM to implement the new pathway more efficiently while preserving resources for future reviews of additional jurisdictions that may not yet have received recognition elsewhere.

The first group of jurisdictions listed in the attached draft policy document consist of countries whose postgraduate training and certification systems have already received significant recognition within Canada and that have been adopted by multiple Canadian MRAs through approved jurisdiction or comparable pathways.

Phase 2

Once an initial group of jurisdictions has been evaluated, CPSM anticipates that Council may wish to consider additional jurisdictions that do not yet satisfy the above criteria. Future reviews could include jurisdictions that:

- Have been reviewed through a rubric under development by FMRAC (see note below);
- Have strong accreditation and regulatory systems but have not yet undergone formal review by a national certifying body;
- Demonstrate substantial equivalency through alternative evidence; or
- Are identified as strategic priorities due to workforce needs.

In respect of the FMRAC rubric: CPSM in collaboration with our national partners, including other Medical Regulatory Authorities (MRAs) and FMRAC, are actively developing a proposed framework to guide further jurisdictional recognition. The objective is to establish a transparent, evidence-informed, and defensible process that recognizes high-quality medical education and training systems while maintaining appropriate standards for public protection.

Factors to consider as part of future jurisdictional recognition include:

- Educational and postgraduate accreditation standards;
- Certification and examination systems;
- Requirements for independent practice;
- Ongoing competency and professional development requirements;
- Regulatory oversight mechanisms;
- Complaint and discipline processes;
- Scope of practice and workforce considerations; and
- Any other factors Council considers relevant.

In some case, there may be good policy rational to recognize jurisdictions without determining postgraduate training equivalency (a requirement of the current regulations). In this regard, CPSM is considering further regulatory amendments to grant Council broader discretion to approve jurisdictions.

While no decision regarding Phase 2 is to be contemplated today, this is being shared to ensure Council is aware of ongoing research, policy development, and possible regulatory changes that will be brought forward in the near future.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 23, 2026, DR. KEVIN CONVERY, PRESIDENT-ELECT, WILL MOVE THAT:

Council approve the attached Council Policy - Approved Jurisdictions.

Notice of Motion Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation

COUNCIL POLICY
Approved Jurisdictions

Initial Approval: **Effective Date:**

Purpose

The Approved Jurisdictions Route provides an alternative pathway to registration for physicians who have both completed postgraduate clinical training and obtained certification in jurisdictions recognized by CPSM as having standards substantially equivalent to those required in Canada. This route supports the registration of physicians who satisfy the requirements of section 3.8 of the *CPSM General Regulation*, including applicants who have completed a substantively equivalent postgraduate clinical training program in an Approved Jurisdiction.

For the purposes of this Policy, an Approved Jurisdiction means a jurisdiction that has been approved by Council in accordance with subsection 3.8(1)(b)(i.3) of the *CPSM General Regulation*. To be registered and licensed under CPSM's Approved Jurisdiction Route, applicants must have achieved licensure in the Approved Jurisdiction where they trained and were certified.

It is important to note that applicants who meet the requirements for the Approved Jurisdiction Route must still meet all of CPSMs common and non-exemptible requirements (fitness and suitability to practice).

Approved Jurisdictions: Family Medicine/General Practice

The following jurisdictions are Approved Jurisdictions for Family Practice. Approvals are based upon recognition by the College of Family Physicians of Canada (CFPC) and numerous other Canadian Medical Regulatory Authorities (MRAs) and evidence of substantial equivalency of training and certification standards:

Country	Qualification
Australia	Graduates of Australian General Practice Vocational Training programs that have been accredited by the Australian Medical Council (AMC) and meet the standards of the Royal Australian College of General Practitioners

Country	Qualification
	(RACGP) who also hold Fellowship of the Royal Australian College of General Practitioners (FRACGP).
	Graduates of the vocational training routes accredited by the AMC and administered through the Australian College of Rural and Remote Medicine (ACRRM) who also hold the certification in family medicine leading to Fellowship of the Australian College of Rural and Remote Medicine (FACRRM).
Ireland	Graduates of general practice vocational training schemes that have been accredited by the Irish College of General Practitioners (ICGP) who also hold Membership of the Irish College of General Practitioners (MICGP).
United Kingdom	Graduates of general practice vocational training programs that have been accredited by the General Medical Council (GMC) who meet the standards of the Royal College of General Practitioners (RCGP) who also hold a Certificate of Completion of Training (CCT) in general practice.

Note regarding the United States: While the CFPC also recognizes training and certification from the United states, that is not included in the above table. The reason is that this is already addressed in subsection 8(1)(b)(i.2) of the *CPSM General Regulation,* which provides a pathway to full registration for applicants who hold

- a licence issued by the medical board of a state of the United States to engage independently in the practice of medicine, and
- Member Board certification and has satisfactorily completed a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (USA).

This covers graduates of family medicine residency training programs that have been accredited by the ACGME and who hold the Diplomate of the American Board of Family Medicine (DABFM) designation.

Approved Jurisdictions: Specialists

The following jurisdictions are Approved Jurisdictions for specialist registration. Approvals are based upon recognition by the Royal College of Physicians and Surgeons of Canada (RCPSC) and by numerous other Canadian MRAs and evidence of substantial equivalency of training and certification standards:

Country	Jurisdiction	Specialties & subspecialties	Dates of acceptable training
	The Australian and New Zealand College of Anaesthetists	Anesthesia. Anesthesia training done from 1985 to 1992 under the Faculty of Anaesthetists of the Royal	1992 to present

		Australasian College of Surgeons is acceptable.	
	Australasian College for Emergency Medicine (ACEM)	Emergency Medicine	1993 to present
	Australasian College of Dermatologists	Dermatology	2000 to present
	Australasian Faculty of Rehabilitation Medicine	Physical Medicine and Rehabilitation	2000 to present
	Australasian Faculty of Occupational Medicine	Occupational Medicine	2000 to present
	Australian Faculty of Public Health Medicine	Community Medicine (Public Health and Preventive Medicine)	2000 to present
	Royal College of Pathologists of Australia	Anatomical Pathology; General Pathology	2000 to present
	Royal Australian and New Zealand College of Psychiatrists	Psychiatry	2000 to present
Australia and New Zealand	The Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG)	Obstetrics and Gynecology; subspecialties of Obstetrics and Gynecology	1996 to present
	The Royal Australian and New Zealand College of Ophthalmologists	Ophthalmology	1995 to present
	The Royal Australasian College of Surgeons	Specialties: Cardiac Surgery, General Surgery, Neurosurgery, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Urology.	1985 to present

		Subspecialties include Pediatric General Surgery, Vascular Surgery, Thoracic Surgery (Cardiothoracic Surgery).	
	The Royal Australian and New Zealand College of Radiologists	Diagnostic Radiology; Radiation Oncology	1975 to present
Australia and New Zealand	The Royal Australian College of Physicians *The Australian Medical Council*	Adult Internal Medicine: Internal Medicine (General Medicine), Medical Genetics (Clinical Genetics), Neurology, Nuclear Medicine Pediatrics: Hematological Pathology (Clinical Hematology & Oncology), Pediatrics, Medical Genetics (Clinical Genetics), Neurology, Nuclear Medicine, Physical Medicine & Rehabilitation (Rehabilitation Medicine) Subspecialties: Adult Internal Medicine: Cardiology, Clinical Immunology & Allergy (Immunology & Allergy), Clinical Pharmacology, Critical Care Medicine (Intensive Care Medicine), Endocrinology & Metabolism (Endocrinology), Gastroenterology (Gastroenterology & Hepatology), Geriatric Medicine, Hematology, Infectious Diseases, Medical Oncology, Nephrology, Palliative Medicine, Respirology (Thoracic Medicine), Rheumatology Pediatrics: Cardiology, Pediatric Emergency Medicine, Clinical Immunology & Allergy (Immunology & Allergy), Critical Care Medicine (Intensive Care Medicine),	1990 to present

		Endocrinology & Metabolism (Endocrinology), Gastroenterology (Gastroenterology & Hepatology), Hematology, Infectious Diseases, Neonatal-Perinatal Medicine, Nephrology, Palliative Medicine, Respirology (Thoracic Medicine), Rheumatology	
Hong Kong	The Hong Kong Academy of Medicine and constituent colleges	Anesthesia, Diagnostic Radiology, Nuclear Medicine, Radiation Oncology, Community Medicine, Emergency Medicine, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pediatrics, Pathology, Psychiatry	1994 to present
Singapore	The Academy of Medicine, Singapore; Division of Graduate Medical Studies, National University of Singapore	Specialties and subspecialties including Anaesthesia, Cardiac Surgery, Community Medicine, Dermatology, Diagnostic Radiology, Emergency Medicine, General Surgery, Pathology, Internal Medicine, Neurology, Neurosurgery, Nuclear Medicine, Obstetrics and Gynecology, Otolaryngology, Ophthalmology, Orthopaedic Surgery, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Psychiatry, Urology, Medical Oncology, Occupational Medicine, Thoracic Surgery, Cardiology, Endocrinology and Metabolism, Gastroenterology, Geriatric Medicine, Hematology, Infectious Diseases, Nephrology, Pediatric General Surgery, Respirology, and Rheumatology.	2000 to present
South Africa	Health Professions Council of South Africa; Colleges of Medicine of South Africa	Specialties and subspecialties including Anatomical Pathology, Anaesthesia, Cardiac Surgery, Community Medicine, Dermatology, Diagnostic Radiology, General Pathology, General Surgery,	1974 to present; Emergency Medicine from 2007 to present

		Hematological Pathology, Internal Medicine, Medical Genetics, Medical Microbiology, Neurology, Neurosurgery, Nuclear Medicine, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pediatrics, Plastic Surgery, Psychiatry, Radiation Oncology, Urology, Vascular Surgery, Thoracic Surgery, Critical Care Medicine, Forensic Pathology, Medical Oncology, Nephrology, Occupational Medicine, and other listed subspecialties.	
Switzerland	Swiss Medical Association	Specialties and subspecialties including Anaesthesia, Cardiac Surgery, Dermatology, General Surgery, Hematological Pathology, Internal Medicine, Nuclear Medicine, Neurology, Neurosurgery, Obstetrics and Gynecology, Occupational Medicine, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Psychiatry, Urology, Cardiology, Clinical Immunology and Allergy, Clinical Pharmacology, Critical Care Medicine, Endocrinology and Metabolism, Forensic Pathology, Gastroenterology, Hematology, Nephrology, Pediatric Surgery, Pediatric Neurology, Respirology, and Rheumatology.	2000 to present
	Royal College of Anaesthetists (UK); College of Anaesthetists, Royal College of Surgeons in Ireland	Anesthesia	UK: 1990 to present; Ireland: 1996 to present
	Faculty/Royal	Emergency Medicine	1993 to present

	College of Emergency Medicine		
	Royal College of Obstetricians and Gynaecologists (UK)	Obstetrics and Gynecology; Gynecologic Oncology; Reproductive Endocrinology and Infertility; Maternal-Fetal Medicine	1984 to present
	Royal College of Ophthalmologists (UK)	Ophthalmology	1988 to present
	Royal College of Paediatrics and Child Health (UK)	Pediatrics and pediatric subspecialties	1972 to present
	Royal College of Pathologists (UK); Joint Committee on Higher Pathology Training	Anatomical Pathology; Medical Biochemistry	1996 to present
United Kingdom and Ireland	Royal Colleges of Physicians and related higher medical training committees	Community Medicine, Dermatology, Hematological Pathology, Internal Medicine, Medical Genetics, Medical Microbiology, Medical Oncology, Neurology, Nuclear Medicine, Physical Medicine and Rehabilitation, and multiple medical subspecialties.	1972 to present; Ireland: 1994 to present
	Royal College of Psychiatrists (UK)	Psychiatry; Child/Adolescent Psychiatry; Geriatric Psychiatry; Forensic Psychiatry	1975 to present
	Royal Colleges of Surgeons and Joint Committee on Higher Surgical Training	Basic Surgical Training; Cardiac Surgery, Diagnostic Radiology, General Surgery, Neurosurgery, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Radiation Oncology, Urology; Thoracic Surgery; Pediatric General Surgery	1976 to present
	Royal College of Radiologists (UK)	Radiation Oncology; Diagnostic Radiology	1975 to present

While the RCPSC also recognizes training and various certifications from the United states for specialists, that is not included in this table. The reason is that this is already addressed in subsection 8(1)(b)(i.2) of the *CPSM General Regulation,* which provides a pathway to full registration for applicants who hold (A) a licence issued by the medical board of a state of the

United States to engage independently in the practice of medicine, and (B) Member Board certification and has satisfactorily completed a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (USA).

Summary of Requirements

Requirement	Family Practice	Specialists
Acceptable medical degree	Required	Required
Postgraduate clinical training	Required	Required
Certification from approved jurisdiction	Verified	Verified
Evidence of independent practice eligibility in approved jurisdiction	Required	Required
Certificates of Professional Conduct	Required from all jurisdictions of registration	Required from all jurisdictions of registration
Criminal Record Check	Required	Required
English Language Proficiency (unless exempt)	Required	Required

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR DISCUSSION BRIEFING NOTE

SUBJECT: **AI Report and Advice to the Profession Update**

Purpose:

The purpose of this agenda item is three-fold:

1. To provide Council with a report that CPSM has completed examining recent developments in the use of generative artificial intelligence (AI) in the practice of medicine over the past few years, including emerging regulatory approaches, professional guidance, scholarly literature, and evolving risks. The report is attached as ***Appendix A***.
2. The report includes recommendations for CPSM, including proposed updates to CPSM's *Advice to the Profession* document regarding registrant use of generative AI. CPSM is seeking comment and feedback from Council on these recommendations.
3. This briefing note also asks for comment and input from Council on further policy work and registrant outreach in this area.

Background:

The use of generative AI technologies in health care has evolved rapidly over the past several years. Registrants increasingly have access to AI tools that can assist with clinical documentation, administrative tasks, information retrieval, patient communication, drafting of reports and letters, education, and clinical decision support. At the same time, regulators, governments, health organizations, professional bodies, and practice settings have continued to develop guidance regarding the safe, ethical, and appropriate use of these technologies in clinical practice.

Recognizing the pace of change in this area, CPSM undertook a review of developments occurring over the past year, with particular attention to:

- Emerging regulatory approaches adopted by medical regulators;
- Published scholarly literature;
- Opportunities and risks associated with registrant use of generative AI;
- Issues relating to use of AI in clinical decision-making;
- Issues relating to use of AI and deskilling; and
- Considerations relevant to CPSM's regulatory mandate.

Report Overview:

The attached report provides a summary of significant developments in the generative AI landscape and identifies several themes that have emerged across the literature and regulatory community. In particular, the review found increasing consensus that:

- Generative AI technologies are likely to become a routine component of medical practice;
- Registrants remain responsible and accountable for clinical decisions regardless of whether AI tools are used;
- AI-generated outputs require appropriate verification and professional oversight;
- Privacy, confidentiality, and information governance considerations remain critically important;
- Transparency regarding AI use is increasingly expected; and
- Regulators have an important role in assisting registrants to use these tools safely and effectively.

The report identifies ongoing uncertainty in several regulatory areas, including documentation expectations, patient disclosure practices, reliability thresholds, the role of AI in clinical decision-making, and risks associated with deskilling.

Important areas not covered in the report that should be addressed soon include the use of generative AI in medical education and assessment and issues relating to data sovereignty. Special attention should also be given to the evolving area of agentic AI use by health care professionals.

Report recommendations:

1. Updating CPSM's *Advice to the Profession* document based on the contents of the report, including to reflect current evidence, emerging standards, and evolving registrant use of generative AI tools.

Next Steps:

The report is being circulated to Council for review and to support discussion at the September 23, 2026, meeting surrounding recommendations to CPSM contained in the report. Council discussion will provide an opportunity to provide comment and feedback on whether the proposed areas of advice and guidance articulated in the report appropriately reflects CPSM's regulatory objectives.

Discussion will also provide Council with the opportunity to provide comment and input on further policy work or outreach that should be undertaken by CPSM in this area. Further work may include:

1. Continuing to monitor developments in generative AI (and other AI technologies) and related regulatory responses in Manitoba, nationally in Canada, and internationally.
2. Emphasizing important regulatory principles through outreach to registrants that are applicable to AI-assisted medical practice.

3. Conducting a survey of registrants regarding the relevance of the current CPSM Advice document as well as use by of AI by registrants.

Council actions:

1. Review the accompanying report on trends in the use of generative AI in the practice of medicine as well as the recommendations contained in the report and provide comments or feedback.
2. Provide comment and feedback on further policy work or outreach that should be undertaken by CPSM in this area.

For Discussion Briefing Note prepared by: Mr. Jeremy de Jong, Director of Registration and Innovation

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Artificial Intelligence in Clinical Practice (2025 – 2026)

Report on Emerging Regulatory Developments & Use of AI in Clinical Practice

Prepared for CPSM, August 2026
Jeremy de Jong, Director of Registration and Innovation

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1. Introduction

The topic of Artificial Intelligence (AI) use in healthcare professions is receiving significant attention in many jurisdictions, including Manitoba. This is the dominant emerging issue for health professions regulators worldwide, particularly regarding governance frameworks for professional accountability. It has been consistently recognized that existing regulatory and governance frameworks were not built for generative AI, LLMs, and autonomous decision supports, which has prompted significant work to define scope, liability, and safety standards for responsible AI use.

A list of publications from Canadian Medical Regulatory Authorities (MRAs) regarding the responsible use of AI may be found at **Appendix A**. For its part, CPSM issued its Advice to the Profession on the Responsible use of Artificial Intelligence in the Practice of Medicine in June of 2024. A copy of the Advice to the Professional document may be found at **Appendix B**.

Recent scholarly literature as well as various reports and surveys indicate that many if not most physicians are now using generative AI in their practices, and that this trend is quickly rising. The two most common physician uses are centered on summarizing research and documenting care. In the past year there has been a marked shift from a sentiment of "*can AI do this?*" to "*how should AI be evaluated, governed, and trusted in practice?*".

The purpose of this report is to provide an update from 2025 and 2026 on how the use of AI tools in the practice of medicine is evolving and why that evolution matters to CPSM mandate, including respecting professional accountability and patient safety. The report cites recent regulatory and governance developments, highlights risk areas (i.e., privacy, informed consent, bias, misinformation, and clinician deskilling) and references important recent medical literature and reported incidents. The report contains reference to selected literature, but it is important to note this is a tiny fraction of the available publications, and that research quickly becomes outdated as generative AI models are constantly changing.

Based on the information reviewed, this report includes recommended additions and amendments to CPSM's 'Advice to the Profession on the Responsible use of Artificial Intelligence in the Practice of Medicine'.

2. Increase use of AI in medical practice

Physician use of AI in clinical practice is increasing rapidly. Recent Canadian and US survey data show that AI tools are quickly moving from early experimentation into routine use. If recent US survey data translates to Canada, **it is possible that more than 80% of physicians use AI in some way in their professional practice**.

a. National Survey of Canadian Physicians - 2024 (CMA + Canada Health Infoway)[1]

This survey was commissioned jointly by Canada Health Infoway and the CMA and surveyed 1,145 practising physicians and residents (CMA members) between April 25 and May 16, 2024. It looked at multiple technologies used in practice, including AI. Results include the following:

- In spring of 2024, 7 percent of physicians reported using AI or machine learning in their main practice to support patient care; an increase from 2 percent in 2021.
- The survey included a dedicated section on "*AI-powered Technologies in Physician Practice*", examining both current use and physicians' views on what's needed to support adoption. On perceived priorities to support AI use, physicians ranked highly:
  - an appropriate regulatory/accreditation system (46% "*very high priority*"),
  - training and education for the workforce (44%),
  - physician leadership to champion and guide the appropriate use of AI in healthcare (36%), and
  - policies and guidelines from governments or clinical bodies (35%).
- Of the respondents, 73 percent cited poor system integration or multiple unconnected systems as a major barrier, and 44 percent reported some degree of burnout, framing AI as a potential tool to reduce administrative burden.

b. Physicians and AI Report – 2024 (Medscape Canada)[2]

Medscape Canada surveyed 718 Canadian physicians across 30 specialties in October 2024:

- Forty-seven (47) percent expressed enthusiasm about AI's potential; 31 percent neutral; 22 percent were apprehensive.
- Only 10 percent described themselves as "*very knowledgeable*" about AI in the workplace.
- Seventy-two (72) percent said it's "*very important*" for physicians to become educated about AI tools.

[1] https://insights.infoway-inforoute.ca/2024-national-physician-survey-methodology
[2] https://www.medscape.com/slideshow/2024-Canadian-docs-and-AI-6017628?src=mkm_ret_240920_mscpmrk_ca_doctorsandai&faf=1#2

- Less than 10 percent were already implementing AI, with the most common uses being administrative automation, information-gathering, and shared clinical decision-making.

c. Physician Survey on Augmented Intelligence – 2026 (AMA)[3]

Results from the Americal Medical Association's (AMA's) 2026 Physician Survey on Augmented Intelligence indicate that 81 percent of responding physicians use AI in their practices. The rate in 2023 was thirty-eight 38 percent. The average number of use cases per physician was 2.3 in 2026, up from 1.1 in 2023. The results include:

- The most common physician uses of AI are centered on medical research summarization and clinical care documentation.
- More than three-quarters of physicians believe AI improves their ability to care for patients, up from 65 percent in 2023. The greatest expected advantages are in diagnostic accuracy and work efficiency.
- Forty percent of physicians have balanced attitudes that are equally excited and concerned about AI, citing patient privacy and the integrity of the patient-physician relationship as top concerns.
- Seventy percent of physicians see AI as a tool to automate tasks that contribute to work-related burnout. However, 88 percent are concerned about potential skill loss, particularly among those with 10 years or less in practice.
- Physicians generally support patient use of AI for general health and medication questions, but most are wary of patient use for tasks requiring clinical judgment. Nearly half strongly oppose patients using AI to interpret radiology or pathology results.
- Physicians emphasize the importance of data privacy (86 percent) and robust safety and efficacy validation (88 percent) as critical for broader AI adoption. Clear liability frameworks rank highest among regulatory actions essential to build physician trust and increase adoption of AI tools.
- Shared ownership of AI adoption decisions is a physician priority. Most physicians (85 percent) want to be consulted or directly involved in decisions about AI adoption.
- Strong clinical evidence and practical implementation guides are the most cited support resources for successful AI integration.

[3] https://www.ama-assn.org/system/files/physician-ai-sentiment-report.pdf

3. Regulatory and policy updates from Canada

a. Responsible AI use in medicine is being led by MRAs (2024–2026)

Medical Regulatory Authorities (MRAs) across Canada have issued guidance on ethical AI use in clinical practice, including generative AI and AI scribes. Responsible AI use principles are consistently embedded, which emphasize that AI must be used in a way that is fair, transparent, and accountable. Expectations consistently include the need for human oversight (or human-in-the-loop), informed consent, privacy-protection, and alignment with patient and societal interests. A list of publications from Canadian MRA's may be found at **Appendix A**.

b. *Artificial Intelligence and Data Act* (AIDA) (Jan 2025)

The Artificial Intelligence and Data Act (AIDA) was Canada's first attempt at comprehensive federal legislation to regulate AI. It was introduced in June 2022 (Part 3 of Bill C-27 - the *Digital Charter Implementation Act*, 2022). Its stated objectives were to:

- Establish common requirements across Canada for the design, development, and use of AI systems.
- Prohibit certain conduct in relation to AI systems that could cause serious harm to individuals or their interests.
- Create an AI and Data Commissioner to administer and enforce the legislation.

In essence, AIDA took a risk-based approach (broadly like the existing *EU AI Act*) that concentrated its most stringent obligations on "*high-impact AI systems*".

Bill C-27—including AIDA—terminated on the Order Paper when Parliament was prorogued on January 6, 2025, and all legislative progress was lost. As of mid-2026, no replacement AI-specific statute has been tabled, and Canada has no comprehensive federal AI law in force. Government has indicated that a renewed national AI strategy is expected later this year.

In this context, AI oversight in heathcare remains fragmented. Health Canada regulates AI only when it qualifies as a medical device. The remaining gap is currently being filled by existing federal laws (PIPEDA, the *Canadian Human Rights Act*), provincial measures (e.g., Quebec's Law 25, Ontario's Bill 194), and sector-specific rules. Sector-specific rules include those made by professional regulators, provincial privacy regulators, and tort law established in the courts.

c. Shift toward accreditation and validation outside Health Canada (2025)

Health Canada and other medical device regulators internationally continue with work focused on how AI should be regulated, and when it should be considered a medical device. The gap is recognized but is not yet addressed. In the interim, Pan-Canadian AI for Health (AI4H) Guiding Principles were endorsed by most federal, provincial, and territorial health ministers in early 2025.

In the current state (including in the above context), **oversight is moving toward organizational governance, accreditation and validation**. Independent bodies (e.g., Health AI validation initiatives) are stepping in to fill the gap for AI scribes, operational AI, and clinical decision support that falls outside current device definitions. In this context, health authorities are expected to demonstrate local validation, monitoring, and equity review, despite a paucity of expertise.

Shared Health provides a local example. They have enacted a Use of Generative Artificial Intelligence Policy governing AI use across its network. Their work includes supporting AI scribe tools in Shared Health-governed electronic medical records (EMRs) and by eligible providers participating in Canada Health Infoway's AI Scribe Program. They have also established guidance on use of research summary tools.

The above approach (institutional accreditation and validation) is also largely being taken in the US. There, the Joint Commission and Coalition for Health AI (CHAI) released the first national guidance for responsible AI use in U.S. health systems (September 2025), which focuses on:

- local validation,
- monitoring,
- governance structures, and
- organizational accountability.

The WHO released guidance on ethics, governance, and regulation of large multimodal AI models in healthcare. Guidance emphasizes:

- Transparency,
- Evidence generation,
- Human oversight, and
- Avoidance of inequity and automation-driven harm.

The WHO guidance is increasingly referenced by national regulators, government agencies and procurement agencies. It creates pressure for documentation, explainability, and accountability.

4. A Selection of Clinical Research Publications Regarding AI (2025 - 2026)

Five publications are summarized in this section to illustrate the state of evidence for AI use in practice. In summary, AI capability is advancing rapidly (Teo), but the evidence base is immature (Han, Chen), methodological and reporting quality is inconsistent (Morone), and governance and reporting frameworks remain underdeveloped, including on applicability, equity, and reproducibility (Shiferaw). All point toward the need for standardised evaluation, real-world validation, and patient-important outcomes before broad clinical reliance. Recommendations exist for institutional governance frameworks (Yang).

a. Guidelines and standard frameworks for artificial intelligence in medicine: a systematic review (2025).[4]

This review appraised the quality of AI governance and reporting standards. It looked at 11 major international guideline frameworks. The article focuses on how AI should be evaluated, reported, and governed, not just performance. Conclusions:

- Guidelines are strong on scope and ethics, weak on real-world applicability.
- Transparency, reproducibility, and equity remain underdeveloped.
- Calls for integration with FAIR data principles[5] and open science.

b. Artificial intelligence in clinical medicine: a state-of-the-art overview of systematic reviews with methodological recommendations for improved reporting (2025). [6]

This overview synthesised 161 systematic reviews. It is a large synthesis on AI in clinical medicine, spanning: oncology, radiology, cardiology, neurology, and rehabilitation. It introduces the CLASMOD-AI classification (built on input, model, data training, and performance metrics) to standardise reporting. Conclusions:

- Diagnostic applications dominate in these practice areas (~44%), especially in oncology.
- Methodological quality is highly variable; risk-of-bias reporting is inconsistent.
- Strong call for standardized evaluation and reporting before further clinical deployment.

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[4] Shiferaw KB, Roloff M, Balaur I, Welter D, Waltemath D, Zeleke AA. Guidelines and standard frameworks for artificial intelligence in medicine: a systematic review. *JAMIA Open.* 2025;8(1): ooae155. https://academic.oup.com/jamiaopen/article/8/1/ooae155/7942556

[5] FAIR data principles (Findable, Accessible, Interoperable, Reusable) are a set of widely used standards for managing research and health data so that it can be responsibly reused, evaluated, and shared.

[6] Morone G, De Angelis L, Martino Cinnera A, et al. Artificial intelligence in clinical medicine: a state-of-the-art overview of systematic reviews with methodological recommendations for improved reporting. *Front Digit Health.* 2025;7:1550731.

c. Generative artificial intelligence in medicine (2025).[7]

This frequently cited publication on generative AI in medicine from 2025. It is a consensus-level review, which discusses foundation models, multimodal AI, agentic systems, and clinical deployment. The publication establishes a vocabulary that is now used broadly in medical research and policy. It maps a clear development pipeline (pretraining, to fine-tuning including RLHF/RLAIF, to deployment via retrieval-augmented generation (RAG)). The authors argue that generative AI is progressing from documentation into diagnostics and multi-step clinical reasoning while requiring less training data. The review stresses that human-in-the-loop design and rigorous real-world evaluation and governance lag far behind deployment.

d. Generative artificial intelligence in public health: a framework for governance and systemic integration (2026)[8]

This review analyses the integration of generative AI into public health systems through a co-evolutionary lens, demonstrating that successful deployment depends heavily on a system's infrastructural, institutional, and workforce maturity. Grounded in the theory of Responsible Innovation, the authors address core challenges across technical transparency, institutional accountability, and ethical equity, such as algorithmic bias, regulatory lag, and technical opacity. To navigate these hurdles, the paper proposes a three-layer governance framework emphasizing that building trustworthy, human-centred AI ecosystems requires institutional foresight, risk-tiered governance, and equitable benefit distribution alongside technical refinement.

e. LLM-assisted systematic review of LLMs in clinical medicine (2026)[9]

This paper presents an LLM-assisted systematic review evaluating the evidence base for LLMs used in clinical medicine. The authors analyse 4,609 peer-reviewed studies published between January 2022 and September 2025, looking at publishing trends, data quality, and model performance relative to human clinicians. Findings include:

- Medical LLM research grew at an average rate of 3.2 papers per day. However, most studies relied on synthetic data, exam questions, or simulated scenarios. 1,048 studies used real-world patient data, and 19 were prospective randomized controlled trials.

[7] Teo ZL, Thirunavukarasu AJ, Elangovan K, et al. Generative artificial intelligence in medicine. *Nat Med.* Published online October 6, 2025.
[8] Yang R, Deng M, Zheng X, Deng Y, Jiang J, Miao J. Generative artificial intelligence in public health: a framework for governance and systemic integration. Front Med. 2026;13:1614656.
[9] Chen, S. F., Alyakin, A., Seas, A., Yang, E., Choi, J. J., Lee, J. V., Chen, A. L., Warman, P. I., Bitolas, R. T., Steele, R. J., Alber, D. A., & Oermann, E. K. (2026). LLM-assisted systematic review of large language models in clinical medicine. Nature Medicine, 32, 1152–1159.

- OpenAI models (such as versions of ChatGPT and GPT-4) accounted for 65.7% of all evaluated models, followed by Google's Gemini/Bard at 13.1%. Closed-source models made up 87.7% of all models studied.
- The most frequently evaluated tasks were patient-facing communication and education (17.4%) and knowledge retrieval/clinical Q&A (12.7%). The most common datasets tested were clinician board/self-assessment questions (22.7%).
- In 1,046 head-to-head comparisons, LLMs outperformed human comparators in 33% of cases. Performance varied significantly by task type and human experience—LLMs outperformed humans more frequently on knowledge-retrieval exams than in real-world clinical tasks, and they outperformed medical learners more often than attending physicians.
- At least 25% of all included studies had sample sizes below 30. Additionally, less than half of the evaluated datasets (42.6%) were open-access, limiting research reproducibility.

Conclusions include that while interest and publication volume surrounding clinical LLMs have surged, high-quality, patient-centred evidence remains scarce. The authors emphasize the need for larger prospective clinical trials before widespread clinical adoption.

5. AI Related De-Skilling (2025 - 2026)

Based on recent literature, deskilling has moved from a theoretical concern (essentially how it is framed in CPSM's Advice document) to a matter of significant and direct regulatory relevance. A cluster of 2025–2026 publications now document automation bias, loss of clinical competence, and training erosion as real, measurable harms rather than speculative risks. This supports extending oversight to monitoring human performance effects and what is needed to preserving clinician independent judgment.

a. Endoscopist Deskilling Risk After Exposure to AI in Colonoscopy (2025)[10]

A Lancet Gastroenterology & Hepatology multicenter observational study across four endoscopy centers in Poland provided the first real-world evidence of automation-induced deskilling linked to patient outcomes in medicine. Examining 1,443 non-AI-assisted colonoscopies before and after routine AI introduction, it found that the adenoma detection rate (ADR) fell significantly from 28.4% to 22.4% once clinicians had become accustomed to AI assistance. The authors concluded that continuous AI exposure may negatively alter endoscopist behaviour, with commentators noting a striking "*paradox of excellence*", the highest performers appear most at risk of slippage.

b. Preserving Clinical Skills in the Age of AI Assistance (2025)[11]

This article introduced a now widely cited taxonomy of skill erosion:

- deskilling (loss of existing skills),
- mis-skilling (adopting errors or bias from AI), and
- never-skilling (trainees failing to achieve competence in the first place).

Using the colonoscopy study as sentinel evidence and noting prior signals from automated ECG and radiological interpretation, the authors argue that the choices made now about how AI is designed, integrated, and trained around **"*will determine whether these systems elevate our profession or quietly erode the skills that define it.*"**

[10] Budzyń K, Romańczyk M, Kitala D, et al. Endoscopist deskilling risk after exposure to artificial intelligence in colonoscopy: a multicentre, observational study. *Lancet Gastroenterol Hepatol.* 2025;10(10):896–903.
[11] Berzin TM, Topol EJ. Preserving clinical skills in the age of AI assistance. *Lancet.* 2025;406(10513):1719.

c. AI-Induced Deskilling in Medicine (2025)[12]

This review synthesized empirical and theoretical evidence across specialties including radiology, neurosurgery, anaesthesiology, oncology, cardiology, and pathology. Anchored in the UK PACES-MRCPUK core competencies, it identifies physical examination, differential diagnosis, clinical judgment, and physician–patient communication as high-risk domains. It introduces the concept of "*upskilling inhibition*" (AI reducing opportunities for trainees to acquire skills) and warns of a "*second singularity*", a scenario in which decision-making autonomy is progressively ceded to AI and human oversight becomes performative rather than substantive. The authors call for longitudinal studies, real-time monitoring, and frameworks to safeguard professional autonomy.

d. Artificial Intelligence and Deskilling in Medicine (2026)[13]

This clinical-ethics analysis focuses on psychiatry and cognitive medicine, where reasoning and communication are central to care. It warns that younger and less experienced clinicians are especially vulnerable to AI-induced deskilling as they increasingly trust and rely on AI recommendations for documentation, treatment plans, and discharge summaries. The authors highlight risks to clinical reasoning, the therapeutic alliance, and diagnostic autonomy, emphasising that AI tools may assist with administrative tasks but "*cannot replace the uniquely human interpersonal and reasoning skills of physicians.*"

e. Deskilling Dilemma: Brain Over Automation (2026)

This education-focused review frames deskilling as a neuro-educational and training problem spanning the continuum from undergraduate education to residency to independent practice. It argues that early-career clinicians are at greatest risk due to premature cognitive offloading, and calls for AI literacy, deliberate practice without AI, and curriculum redesign to preserve the development of foundational competencies.

[12] Natali C, Marconi L, Dias Duran LD, Cabitza F. AI-induced deskilling in medicine: a mixed-method review and research agenda for healthcare and beyond. *Artif Intell Rev.* 2025;58:Article 356.
[13] Monteith S, Glenn T, Geddes JR, Whybrow PC, Achtyes ED, Bauer R, Bauer M. Artificial intelligence and deskilling in medicine. *Br J Psychiatry.* Published online January 8, 2026:1–3.

f. Human deskilling in medical artificial intelligence: prohibited or permissible under the EU Artificial Intelligence Act?[14]

This commentary addresses the legal and clinical implications of AI-induced human deskilling in medicine under the *EU AI Act,* which regulates high-risk AI practices and sets explicit requirements for risk management, transparency, and human oversight. The authors question whether routine reliance on medical AI, such as computer-aided detection systems in gastroenterology and colonoscopy, can lead to an erosion of a physician's cognitive, diagnostic, and procedural skills over time. And, if so, whether this runs afoul of the *EU AI Act*. The commentary highlights the need for ongoing skill maintenance, educational programs, and regulatory standards to prevent physicians from over-relying on automated assistance, ensuring patient safety is not compromised if AI integration increases.

[14] Gerke, S., Hassan, C., & Mori, Y. (2026). Human deskilling in medical artificial intelligence: prohibited or permissible under the EU Artificial Intelligence Act? Nature Reviews Gastroenterology & Hepatology, 23(7), 521–522.

6. AI in the diagnostic process (2025 - 2026)

This section reviews recent publications regarding AI use in diagnostic reasoning and clinical decision support. The examples show both potential benefits and significant safety concerns: AI systems may broaden the differential diagnosis or produce sophisticated reasoning in selected cases, but they can also fail to improve diagnostic quality, reproduce demographic bias, misclassify disease, provide unsafe advice, or perform poorly when required to manage uncertainty. Together, the literature cited below reinforces that AI should support, not replace, clinical judgment, and that diagnostic use requires careful validation, human oversight, and clear professional accountability.

a. Computerized diagnostic decision support in diagnosis (2025)[15]

A multicentre Swiss emergency department trial found that use of the Isabel Pro computerized diagnostic decision support system did not improve diagnostic quality compared with usual care. Diagnostic-quality risk, defined by unplanned medical follow-up, retrospective diagnosis change, unexpected ICU admission, or death within 14 days, occurred in 18% of patients in both the AI-supported and usual-care groups.

b. LMM diagnostic bias leading to inappropriate diagnostic pathways (2025)[16]

In this publication, the authors stress-tested nine LLMs across 1,000 emergency cases in 32 demographic variations, generating over 1.7 million recommendations. Holding clinical details constant, cases labelled as Black, unhoused, or LGBTQIA+ were disproportionately steered toward urgent care, invasive interventions, or mental-health evaluations—LGBTQIA+ subgroups were flagged for mental-health assessment six to seven times more often than clinically indicated, while high-income labels drew significantly more advanced imaging (CT/MRI). These disparities persisted after statistical correction and were not supported by clinical reasoning.

[15] Hautz, W. E., Marcin, T., Hautz, S. C., Schauber, S. K., Krummrey, G., Müller, M., et al. (2025). Diagnoses supported by a computerised diagnostic decision support system versus conventional diagnoses in emergency patients (DDX-BRO): a multicentre, multiple-period, double-blind, cluster-randomised, crossover superiority trial. *The Lancet Digital Health*, *7*(2), e136–e144.

[16] Omar, M., Soffer, S., Agbareia, R., Bragazzi, N. L., Apakama, D. U., Horowitz, C. R., Charney, A. W., Freeman, R., Kummer, B., Glicksberg, B. S., Nadkarni, G. N., & Klang, E. (2025). *Sociodemographic biases in medical decision making by large language models*. Nature Medicine, 31, 1873–1881.

c. AI misclassification of pediatric diseases (2024)[17]

This study tested ChatGPT 3.5 on 100 pediatric case challenges drawn from JAMA Pediatrics and New England Journal of Medicine pediatric cases. It found a diagnostic error rate of 83%: 72 incorrect diagnoses and 11 diagnoses that were related but too broad to be considered correct. For example, a "*missed nutritional deficiency*" is the case of "*arthralgia and rash in a teenager with autism*", where the chatbot suggested "*immune thrombocytopenic purpura*" but the physician diagnosis was "*scurvy*". A "*misidentified congenital syndrome*" example is an infant with a draining papule on the lateral neck, where the chatbot suggested "*branchial cleft cyst?*" but the physician diagnosis was "*branchio-oto-renal syndrome*".

d. A case of bromism influenced by use of artificial intelligence (2025)[18]

This case study reports: A 60-year-old man was concerned about dietary salt, asked ChatGPT for a sodium chloride substitute and was pointed toward bromide, an early anticonvulsant that is toxic when it accumulates. After sourcing it online and consuming it for roughly three months, he presented to the ED with paranoia (believing his neighbour was poisoning him), extreme thirst, hallucinations, and a bromide level hundreds of times above normal; he was ultimately placed on an involuntary psychiatric hold. When the treating physicians replicated the query, ChatGPT again suggested bromide without a specific health warning.

e. ChatGPT-Assisted Diagnosis of Tularemia (2025)[19]

Kim et al. describe a 2025 case report in which a 55-year-old man with prolonged nonspecific symptoms ultimately received a diagnosis of tularemia after patient-initiated use of ChatGPT helped identify the rare zoonotic infection as a possible explanation. The diagnosis was later confirmed through appropriate laboratory testing. The case illustrates how generative AI may assist by broadening the differential diagnosis in rare or atypical presentations, but it remains anecdotal evidence and does not establish that AI can safely or reliably diagnose patients without clinician oversight.

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[17] Barile, J., Margolis, A., Cason, G., et al. (2024). Diagnostic Accuracy of a Large Language Model in Pediatric Case Studies. JAMA Pediatrics, 178(3), 313–315.

[18] Eichenberger et al. A case of bromism influenced by use of artificial intelligence. *Ann Intern Med Clin Cases.* 2025;4(8). Published August 5, 2025.

[19] Kim, J., Müller, N., Wagelöhner, T., Köppen, D., Jacob, D., Heuner, K., Khalifa, A. A., & Stephan, L. U. (2025). *The Use of ChatGPT in Diagnosing Tularemia – A Case Report on the Associated Challenges and Treatment*. Annals of Clinical Case Reports, 10, Article 2729

f. Large language model performance and clinical reasoning tasks (2026)[20]

This cross-sectional study evaluated the end-to-end clinical reasoning capabilities of 21 LLMs across sequential stages of clinical workflow. To address limitations in traditional benchmark evaluations (such as multiple-choice tests), the authors introduced a multidimensional metric called the Proportional Index of Medical Evaluation for LLMs (PrIME-LLM) score.

- Overall Performance & Benchmark Scores:
  - PrIME-LLM scores ranged from 0.64 (Gemini 1.5 Flash) to 0.78 (Grok 4).
  - Top-performing models included Grok 4, GPT-5, GPT-4.5, Claude 4.5 Opus, Gemini 3.0 Flash, and Gemini 3.0 Pro.
  - Raw accuracy obscured distinct performance gaps, whereas the PrIME-LLM framework highlighted variations across reasoning stages.
- Reasoning Capabilities:
  - Reasoning-optimized models significantly outperformed non-reasoning models.
  - Models across the board showed the weakest performance in generating differential diagnoses (failure rates exceeding 80%).
  - Performance was strongest for final diagnosis, management, and miscellaneous clinical reasoning tasks.
- Multimodal Data:
  - Most multimodal LLMs demonstrated improved diagnostic accuracy when provided with image inputs (e.g., chest radiographs, CT scans, and ECGs) compared to text-only prompts.

The authors concluded that while state-of-the-art LLMs excel at reaching final diagnoses given structured clinical data, significant gaps remain in early diagnostic reasoning and managing diagnostic uncertainty. Consequently, off-the-shelf LLMs are not yet ready for unsupervised, patient-facing clinical decision-making.

[20] Rao AS, Esmail KP, Lee RS, et al. Large language model performance and clinical reasoning tasks. JAMA Netw Open. 2026;9(4):e264003.

7. Revisiting CPSM's Advice to the Profession

In addition to above publications, it should be noted that areas of concern regarding generative AI use have appeared anecdotally in CPSM's regulatory work. Examples include:

- Use by individuals undergoing licensure-linked assessment processes, confounding the validity or reliability of the process.
- Use by individuals providing reflection on care or professionalism is CPSM's regulatory processes, obscuring whether respondents are displaying genuine insight.
- Suspected cases of generate AI use in clinical decision-making, including where diagnostic and treatment planning outputs were not appropriate.

Overall, based on the above information, CPSM's current Advice to the Profession remains current and relevant, with two exceptions not addressed in this report (noted below). Core expectations set out in the Advice document regarding professional accountability, patient safety, transparency, informed consent, privacy protection, equity, documentation, and the need for registrants to exercise independent clinical judgment continue to align with emerging Canadian regulatory guidance and the recent literature on AI use in medicine.

The two areas not dealt with in this report relate to use of AI in Health Professional Education and Data Sovereignty concerns. These areas require further focused work and will be looked at in a future review of the Advice document.

With the foregoing in mind, the recommendations in this section are largely targeted refinements to make the expectations more specific, practical, and responsive to current risks.

a. Part 3. Ensuring compliance with applicable professional requirements

The emerging legal position is that AI (particularly generative and agentic AI) does not create a lower or separate standard of care for professionals. Rather, the existing standard of care applies to a decision to use AI and to the clinical judgment exercised when relying on it.

Applying this standard to the practice of medicine, a registrant will be expected to use AI only where a reasonably prudent registrant would consider the tool appropriate for the clinical purpose, understand its limitations, take reasonable steps to verify its outputs, and remain accountable for the final assessment, diagnosis, treatment plan, documentation, and communication with the patient. In this sense, unsafe reliance on AI is best understood not as a failure of technology alone, but as a potential failure of professional judgment, informed consent, documentation, privacy protection, or ongoing competence. The makes misuse of AI a professionalism concern and a potential malpractice concern.

It may be worthwhile to add the foregoing statement, or a variation of it, to the Advice document at Part 3, or alternatively at Part 5. We may include that the Advice document itself should be seen a as a benchmark for due diligence.

b. Part 4. Continuing professional development is necessary

Given recent publications, it may be worthwhile to specifically emphasize in the Advice document that CPD should focus on practical AI literacy and the preservation of core clinical competence.

Registrants should be supported to understand how AI tools work, what they are designed to do, where they may fail, and how to verify clinically material outputs before relying on them. CPD should also address privacy, consent, documentation, bias, automation bias, model drift, and the limits of patient-facing public AI tools.

Given the emerging evidence on AI-related de-skilling, CPD should explicitly reinforce that registrants must maintain the ability to assess, diagnose, reason, communicate, and practice safely when AI is unavailable, inaccurate, or inappropriate. In this sense, responsible AI education should not only teach registrants how to use AI, but also how to preserve independent professional judgment and avoid over-reliance.

c. Part 5. Responsible use of GenAI tools and accountability

Part 5 of the Advice document would likely benefit from more explicit language regarding de-skilling. In particular, section 5.17 should:

- identify over-reliance on AI and loss of core clinical skills as patient-safety risks,
- emphasize that registrants must maintain the ability to practice safely when AI is unavailable, inaccurate, or inappropriate, and
- encourage practice settings to support monitoring, education, and governance measures that preserve independent clinical judgment.

Further additions to consider:

- explicitly name de-skilling, mis-skilling, and never-skilling as risks;
- state that over-reliance on AI may impair clinical reasoning, diagnosis, communication, and procedural competence; and
- add the concept of "*AI-off competence*".

In terms of governance and policy at the practice setting level, section 5.10 could more clearly state that responsible AI use depends on the safeguards in the practice setting where the tool is

deployed. Registrants should ensure that any AI tool used in clinical care is supported by appropriate local governance, including a responsible AI use policy, privacy and security review, clear accountability for implementation, local validation where appropriate, monitoring for accuracy, bias, equity impacts, and model drift, and a process for reporting concerns or adverse events.

It may also be important to highlight: Where an AI tool is not regulated as a medical device, such as an AI scribe, administrative tool, or general-purpose generative AI system, the absence of device regulation should not be understood as confirmation that the tool is safe for clinical use. In those circumstances, registrants and practice settings should take reasonable steps to confirm that the tool has been reviewed, approved, and monitored for the intended clinical or administrative purpose.

d. Part 7. Complete and accurate documentation

The current patient records section (7.3.2.) notes an AI generated recording or transcript used in creating a note by an AI scribe may form part of the patient record that needs to be retained. At least one other MRA (CMQ) found such records may be consider a draft note that need not be retained. CPSM should likely follow suit, as this is a logical conclusion.

e. Part 11. Health system harm.

This section could be strengthened with additional areas of concern that have been identified in the literature.

AI tools (depending on their nature and where they are implemented) may affect access to care, triage decisions, referral pathways, resource allocation, workload distribution, documentation quality, and public trust. Where a tool is inaccurate, biased, poorly monitored, or deployed without adequate human oversight, its effects may be multiplied across many patients and may disproportionately affect patients who already experience barriers to care. For this reason, responsible AI use should include attention to system-level risks such as inequitable access, automation-driven delays, barriers to or denials of care, inappropriate substitution of AI for clinical assessment, increased administrative burden, erosion of professional judgment, and reduced ability to detect errors once AI outputs become embedded in routine workflows.

Registrants and practice settings should be encouraged to identify, monitor, and report not only individual adverse events, but also patterns of AI-related harm that may affect patient populations or the safe functioning of the health system.

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f. Part 12. Patients using AI.

Part 12 could be strengthened by recognizing that patients are increasingly using public AI tools to seek health information, interpret symptoms, review test results, identify possible diagnoses, or decide whether to seek care.

The Canadian Medical Association (CMA) published a February 2026 Health and Media Tracking Survey revealing that while only 27% of Canadians trust AI for health information, about half still use AI tools to diagnose or treat health issues. Findings include:

- 89% of Canadians go online for health information because it is faster and more convenient than the formal health care system.
- Roughly 52% use AI search results for health info, and 48% use them for treatment advice, despite low trust.
- People who followed medical advice from AI were five times more likely to experience negative health effects or adverse reactions.
- 77% of respondents worry about false health information coming from the U.S., and 69% are now sceptical of any health information found online.

In the above context, where a patient presents with AI-generated information that is inaccurate, unsafe, unsupported, or inconsistent with the clinical assessment, physicians should take reasonable steps to correct the misunderstanding, explain the limits of the information, and provide appropriate medical advice. CPSM may wish to consider adding a public-facing statement, or linking to one, making clear that general-purpose chatbots are not endorsed as a substitute for medical assessment, diagnosis, treatment, or emergency care.

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APPENDIX A – Advice documents from Canadian Medical Regulatory Authorities (MRAs) on responsible AI use.

MRA	Publication	Year and type	Key Focus
CPSBC (BC)	Ethical Principles for Artificial Intelligence in Medicine	2024, Interim Guidance	Covers privacy, confidentiality, consent, accuracy, reliability, transparency, interpretability, bias, monitoring, oversight, and professional judgment. [cpsbc.ca]
CPSA (AB)	Artificial Intelligence in Clinical Practice	2023; updated 2026, Advice to the Profession	Addresses AI scribes, documentation, clinical decision support, accountability, privacy impact assessments, consent, and documenting AI use in patient records. [cpsa.ca],
CPSS (SK)	Advice to the Profession: Using AI in Clinical Practice	2026, Advice to the Profession	Covers AI scribes, intake and triage tools, clinical decision support, performance drift, privacy, patient consent, accountability, bias, and written agreements with information management service providers. [cps.sk.ca]
CPSM (MB)	Advice to the Profession on the Responsible Use of AI in the Practice of Medicine	2024, Advice to the Profession	Addresses GenAI in practice, accountability, transparency, informed consent, confidentiality, equity, documentation, data sovereignty, health system harm, and patients using GenAI. [cpsm.mb.ca]
CPSO (ON)	Using Artificial Intelligence in Clinical Practice	2025, Advice to the Profession	Covers AI in clinical practice, AI scribes, intake and triage, clinical decision support, physician oversight, and responsible digital health adoption. [cpso.on.ca],
CMQ (QC)	L'IA et la pratique de la médecine; L'intelligence artificielle en médecine	2024 - 2026, guidance	CMQ has a central AI page. The page lists publications on AI training, professional accountability, AI in medicine, AI scribes, and a 2024 reflection document. [cmq.org]

CPSNB (NB)	Artificial Intelligence – Interim Guidance	2024–2025, Interim Guidance	Provides physician obligations pending an AI standard. Notes Health Canada oversight of machine-learning enabled medical devices, cautions about public AI tools, and states physicians should use Health Canada-approved machine-learning enabled medical devices and understand classification, evidence, and limitations. [cpsnb.org]
CPSPEI PEI	Artificial Intelligence (AI) Scribes in Clinical Care	2025, Guidance on AI scribes	Supports cautious use of AI scribes. States registrants remain responsible for their assessments, documentation, and recommendations. Expects patient consent, verification of generated medical records, secure/private AI scribe systems, review for accuracy and completeness, awareness of inaccuracies, and advising patients about documentation use. [cpspei.ca]
CPSNS (NS)	(AI) scribes in clinical care	2025, guidance	Supports AI scribe use to improve charting and reduce administrative burden. Requires record accuracy, reasonable steps to ensure security and privacy, express consent if recording is maintained, and knowledgeable implied consent if no recording is maintained. Also endorses the Nova Scotia Artificial Intelligence (AI) Scribe for Health policy. [cpsns.ns.ca]
CPSNL (NL)	Artificial Intelligence Practice Guideline	2025, guidance	Covers privacy and confidentiality, secure storage and transmission, privacy impact assessment, consent, competencies, bias, reviewing AI-scribe documentation, monitoring, and Health Canada approval where AI falls within the medical device definition. [cpsnl.ca]

Did not find published guidance from regulatory authorities in NU, YK, or NWT.

Advice to the Profession:
Responsible use of Artificial Intelligence in the Practice of Medicine

Advice to the profession:

The College of Physicians & Surgeons of Manitoba (CPSM) provides advice to the profession to support registrants in implementing CPSM's Standards of Practice, Practice Directions, and the Code of Ethics and Professionalism. This advice document does not define a Standard of Practice, nor should it be interpreted as legal advice.

In general, advice documents are dynamic and may be edited or updated for clarity at any time. Please refer to this article regularly to ensure you are aware of the most recent advice. Major changes will be communicated to registrants through CPSM's Newsletter; however, minor edits may only be noted within the documents.

Preamble:

It is important for registrants to educate themselves about the responsible and ethical use of artificial intelligence (AI) in practice. This document primarily addresses generative artificial intelligence (GenAI), though most principles have broad application to other forms of AI. The advice provided is centred on the importance of education, accountability, transparency, informed consent, confidentiality, and equity in healthcare. Systems issues are also addressed.

Contents

1. Context for this document

Recent advances in AI[1], such as the public release of new GenAI[2] technologies like ChatGPT (OpenAI) and CoPilot (Microsoft), have stimulated significant discussion around the impact AI will have on the delivery of healthcare. GenAI is in focus given its remarkable ability to create new content, such as diagnoses, treatment plans, and encounter notes (e.g., AI scribes).[3]

While CPSM acknowledges the enormous potential for GenAI to improve accessibility, enhance quality, and reduce administrative burden, we also recognize the significant ethical, legal, and professional challenges that accompany its use, including relating to over-reliance. This document is intended to provide advice to assist registrants in addressing these challenges.

Overall, the use of GenAI in healthcare should minimize potential data-related harm and promote the equitable delivery of safe quality care. As explained below, appropriate precautions anchored in the Code of Ethics and Professionalism are key to responsible use of AI.

2. Potential applications for GenAI in medical practice

AI tools used to support diagnosis, monitoring, treatment planning, and documentation have been around for many years. These include dictation and speech recognition software, electronic medical record (EMR) macros or templates, and automated pathways, protocols, and clinical scores. Software exists that can analyze diagnostic information or identify pharmacological interactions and contraindications. These more traditional tools often rely on machine learning (ML)[4] technology and well-circumscribed datasets.

Large language model (LLM)[5] based GenAI is a major evolution in AI technology that builds upon advances in complex algorithms, advance data analytics and ML. Significantly, GenAI tools can create new content based on existing data and training. Given this capability, the importance of independent clinical judgment and professional accountability is crucial if GenAI is adopted in practice. In this context, there are concerns surrounding the transparency of underlying models and source data in the use of LLM based GenAI that must be understood and managed.

[1] Artificial Intelligence (AI) is an umbrella term that refers to the ability of a machine (e.g., computer) to perform tasks associated with intelligent beings, such as reasoning, language comprehension, and decision making.
[2] Generative AI (GenAI) refers to advanced AI systems that can be prompted to generate new content, including audio, images, text, and videos, in response to prompts from users. GenAI relies on massive datasets and complex underlying algorithms and computer models.
[3] Examples of these technologies include IBM's Merative (formerly Watson Health) and Google's Med-PaLM
[4] Machine learning (ML) refers to a machine's ability to learn from its own experiences rather than relying exclusively on explicit programing. ML involves the use of algorithms that can analyze data, make predictions based on that data, and establish models when applied to data. ML can be supervised or unsupervised.
[5] Large language models (LLMs) are a type of AI that use massive data sets, algorithms, and deep learning to understand context, and generate and predict new content. Models can be fine-tuned on specialized data to produce improved outputs. All LLMs are a form of GenAI.

GenAI tools that support ambient capture of patient consultations and clinician dictations are already being incorporated into medical practice to assist with documentation. These tools are commonly referred to as AI Scribes and, to the best of our understanding, usually do not fall under the definition of a medical device requiring Health Canada approval.[6] That flows from their characterization as a tool to assist with documentation, rather than a clinical decision support tool.

Other potential applications for GenAI in the practice of medicine include tools for generating diagnoses, differential diagnoses, prognoses, prescriptions, treatment plans, educational materials, and medical reports.[7] These clinical decision support applications would require Health Canada approval. While there are many examples of approved medical devices that rely on AI and ML,[8] it is understood no medical devices that use LLM GenAI have been approved as of the last update to this document.[9]

The use of GenAI in healthcare is a rapidly evolving area. In the circumstances, there is currently limited research-based evidence to guide an approach to the use of GenAI tools by registrants, though there are many studies underway. Laws and regulations specific to this field are contemplated or in development at various levels of government.[10] It is anticipated use of GenAI in the practice of medicine will become commonplace in the coming years.

3. Ensuring compliance with applicable professional requirements

3.1. Registrants are reminded that requirements and principles from existing legislation, regulations and professional expectations apply when using any type of AI in their practice. This includes CPSM's Code of Ethics and Professionalism, Standards of Practice of Medicine, and Practice Directions.

3.2. If the AI tool fits the definition of a medical device, then registrants should ensure it is approved by Health Canada. As of the date of this document, it is understood that no LLM GenAI medical devices have been approved. CPSM understands AI Scribes usually do not fall under the definition of a medical device.

[6] See the federal *Food and Drugs Act* and associated Medical Devices Regulations.
[7] Experimental examples include DxGBT, which is described as diagnostic support software, and Med-PaLM (Google Research), which is a LLM designed to provide high quality answers to medical questions.
[8] Medical devices that use ML to achieve their intended medical purpose are known as machine learning-enabled medical devices (MLMDs). The term "Medical purpose" is defined in the federal *Food and Drugs Act*. MLMDs are subject to the *Food and Drugs Act* and associated Medical Devices Regulations.
[9] It is understood that recently approved AI assessment tools for diabetic retinopathy screening and dermatology differential diagnosis suggestions do not rely on LLMs.
[10] See the Office of the Privacy Commissioner of Canada's publication on 'Principles for responsible, trustworthy and privacy-protective generative AI technologies' at https://www.priv.gc.ca/en/privacy-topics/technology/artificial-intelligence/gd_principles_ai/

4. Continuing professional development is necessary

4.1. Registrants have a professional and ethical duty to maintain a requisite level of skill, knowledge, and judgement to provide competent and safe care in their professional practice. Continuing professional development is key to meeting this obligation.

4.2. As AI tools are increasingly incorporated into the healthcare system, which may include GenAI tools, it is important that registrants follow significant developments and strive to understand how the technology works, its limitations, the benefits and risks, and privacy implications.

5. Responsible use of GenAI tools and accountability

5.1. CPSM does not regulate medical devices, tools, or technologies; our role is to regulate registrants who use these tools in their professional practice. The GenAI tools registrants use must be physician guided to create positive and transparent interactions that instill trust. Consistent with the prevailing standards for any technology used in care, registrants are ultimately responsible for their use of GenAI tools and may be held accountable for any harms that flow from use.

5.2. Care provided by a registrant should always reflect their own clinical reasoning and professional judgment. The Canadian Medical Protective Agency (CMPA) makes it clear that AI technologies are intended to assist and complement clinical care. They are not a replacement for clinical reasoning and professional judgment.[11] CMPA also has helpful guidance on the use of AI scribes.[12] Registrants should take steps to avoid over-reliance on GenAI tools to such a degree that it jeopardizes independent professional judgement and vigilance.

5.3. The extent to which a registrant may be held professionally accountable for their use of a GenAI tool will depend on the relationship between the GenAI being used and the risk that it may either create patient harm or otherwise impact the professional obligations of the registrant. As GenAI technologies perform functions that more closely model the practice of medicine, the risk to patients of their application generally increases. The appropriate level of and accountability will increase accordingly.

5.4. If a registrant chooses to use a GenAI tool in their professional practice, then it is important they understand the tool's intended purpose, limitations, risks, and benefits to ensure safe and competent use. Registrants should:

[11] Canadian Medical Protective Association. The emergence of AI in healthcare, 2019 (revised 2023).
[12] CMPA's 'AI Scribes: Answers to frequently asked questions', retrieved from https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2023/ai-scribes-answers-to-frequently-asked-questions

5.4.1. critically assess whether the tool suits its intended purpose in the context of the registrant's practice setting and professional practice,
5.4.2. ensure that the tool is:
5.4.2.1. up-to-date, valid, and reliable,
5.4.2.2. transparent respecting the data it is trained on,
5.4.2.3. explainable to patients, including respecting limitations, and
5.4.2.4. capable of producing good and interpretable output, and
5.4.3. if not using a closed/locked GenAI system, then acknowledge the potential risks of open-source nature of GenAI tools and the issues they could create.

5.5. An adequate understanding of a GenAI tool's design, the training data used in development, and the nature of the tool's outputs is necessary to assess validity, reliability, and to identify and mitigate potential areas of bias. Depending upon the technology, underlying data sources and training may not be transparent, making it difficult to understand the validity and reliability of the technology. Technology that is not transparent should be avoided or, at a minimum, approached with heightened vigilance and caution.

5.6. GenAI outputs may include information that is inaccurate, incomplete, outdated, harmful, biased, or otherwise inappropriate for the medical problem. Registrants must be aware and responsive to this issue. Such content carries the risk of undermining trust and accountability or violating ethical and professional standards.

5.7. The duty of competence requires more than the detection and elimination of false GenAI results. Competence requires the continuous application of clinical reasoning and analysis regarding all potential options and impacts, including those that are included or omitted from or by GenAI tools. Risks associated with the use of GenAI include:
5.7.1. reducing human agency and autonomy by replacing or influencing human decision-making or behaviour; for instance, through complacency or frame-of-reference thinking,
5.7.2. potentially compromising privacy and security by exposing sensitive and confidential data to unauthorized parties or malicious attacks, and
5.7.3. skills degradation over time.

5.8. If a GenAI tool produces clinical decision support or advice related to a specific patient's care, the registrant accepts the responsibility for care delivered. Whether GenAI clinical decision support is followed or ignored, registrants should document the rationale behind the deviation or use of an AI tool designed to give specific advice or guidance.[13]

[13] For example, some GenAI tools used for this purpose, which are noted to be in their research phase, generate an extensive list of differential diagnoses and the rationale for each diagnosis listed. This output should be included in the patient record akin to a consultation.

5.9. Registrants must be aware of conflict-of-interest concerns and guard against them when using AI. The Code of Ethics and Professionalism and CPSM's Standard of Practice for Conflicts of Interest apply in this respect. This is particularly important if AI is used to recommend treatment options, for example specific medications.

5.10. Practice settings should establish applicable policies and procedures for the responsible use of GenAI and update privacy policies accordingly. This should include policies and processes to identify, report, and address concerns about the use of GenAI tools, and the potential for raising issues with vendors or operating organizations.

6. Disclosure and informed consent

6.1. With a novel technology such as GenAI, CPSM recognizes that it may be challenging to communicate the risks and benefits accurately and comprehensively. As a starting point, registrants are reminded that provisions of the Code of Ethics and Professionalism and CPSM's Standard of Practice for Good Medical Care apply respecting disclosure and informed consent regarding the use of GenAI tools in providing care.

6.2. Informed consent is not a list of AI-generated risks and benefits, but instead a meaningful dialogue and shared decision-making between the physician and patient. One of the primary goals of the informed consent process as a component of good care is to ensure patient autonomy in clinical decision-making. This is accomplished both by informing patients about the care they are receiving, including assessment and management decisions, and safeguarding patient privacy. Use of GenAI has implications for these issues and must be disclosed. GenAI may be used to assist in this process but the ultimate responsibility rests with the registrant.

6.3. For informed consent to be valid, a patient must be adequately informed about their diagnosis and treatment options, the risks and benefits involved, and reasonable alternatives. If a GenAI tool is used in clinical decision support, registrants should:

- 6.3.1. disclose how GenAI tool was used,
- 6.3.2. discuss capabilities and limitations of the tool,
- 6.3.3. discuss safeguards that have been put in place to manage bias and ensure validity and reliability, and
- 6.3.4. be able to independently explain components of diagnosis and treatment options to fulfill their professional responsibilities relating to the informed consent process.

6.4. A lack of transparency regarding the role that GenAI has played in the delivery of care and the inability of the physician to communicate with the patient can undermine trust and may serve to highlight the registrant's lack of understanding of

how the GenAI tool works.

6.5. Informed consent is also important for privacy reasons. Because data received during a patient encounter may be entered into GenAI tools, registrants must receive a patient's informed consent in advance of use.[14] This is necessary for tools such as AI Scribes that record patient encounters. The discussion should include the reasons for making the recording, how patient data may be accessed, used, or shared, as well as potential risks involving data integrity and privacy. Patients also need to be informed about their right to refuse, withdraw, or modify consent, and their access and copying rights under PHIA if the recording is maintained as part of the patient record.[15]

7. Complete and accurate documentation

7.1. Currently, the most common use for GenAI is as a clinical scribe. This software interacts with the patient's EMR to automate documentation of care. Without proper oversight, this may lead to incomplete or inaccurate documentation and subsequent patient harm.

7.2. Registrants must be mindful that the requirements of CPSM's Standard of Practice for Documentation in Patient Records applies to documentation created with the support of GenAI. The Standard requires registrants to ensure that the patient record accurately and completely reflects their involvement in care. As such, registrants must not rely on content created by a GenAI system as the sole or final source of information. Rather, they must verify and validate any GenAI-generated content to ensure it is accurate and complete before it is entered into the patient record. Registrants should not attempt to hide the use of GenAI in professional practice.

7.3. Recordings of an encounter as captured by a GenAI tool (e.g., audio, video, and/or transcript) are not explicitly addressed in CPSM's Standard of Practice for Documentation in Patient Records or the Standard of Practice for Maintenance of Patient Records in All Settings. This will need to be considered when those Standards are next reviewed. Meanwhile:

7.3.1. The key is satisfying the requirements of the Standard of Practice for Documentation in Patient Records.

7.3.2. Registrants should assume they are required to retain the complete recording, or transcript if one is generated, as part of the patient record. Additionally, this would be prudent for medico-legal reasons, including if

[14] Express consent is always required to record an encounter with a patient. Depending on the practice setting, it may be wise to share the practice setting's policy and information about the AI in advance.
[15] See CMPA's 'Recording clinical encounters with patients: What physicians need to know', retrieved from https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2023/recording-clinical-encounters-with-patients-what-physicians-need-to-know

the completeness or accuracy of the encounter notes comes into question.[16]

7.4. Registrants are expected to record the context in which documentation is generated. This should include the author's identity, for example the registrant, learner, scribe, or allied healthcare provider. Documentation should include notation of any assistive technology used to generate the note, for example dictation software or an AI scribe.

8. Bias, equity, and respect for persons

8.1. A key professional responsibility in medicine has always been the assurance that clinical decisions and recommendations are not biased. Potential biases and risks related to the use of GenAI can arise from the source data. Biased training data incorporated into GenAI tools may ultimately impact patient care and because of the potential that GenAI could perpetuate, rather than eliminate, bias in healthcare.

8.2. AI systems encumbered by prejudiced, false, or inaccurate information may carry a bias that can be detrimental to providers and harmful to patients. Registrants should therefore make reasonable efforts to identify and address such biases before using GenAI systems in patient care. Registrants should use caution in interpreting AI generated content, accounting for the demographics and health context of the patient they are assessing.

8.3. Registrants are expected to respect the dignity, diversity, cultural values, and rights of patients and colleagues, and avoid using GenAI to create or disseminate content that is discriminatory, offensive, or harmful.

9. Confidentiality and data security

9.1. Registrants are expected to ensure compliance with applicable federal and provincial laws, including PHIA, as well as applicable policies within the practice setting.

9.2. Registrants are legally and ethically required to ensure confidential information, including the patient's personal information and personal health information, is adequately protected.

9.2.1. Registrants should take care not to expose a patient's personally identifiable information when using GenAI to support their clinical care.

[16] See CMPA's 'Recording clinical encounters with patients: What physicians need to know' retrieved from https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2023/recording-clinical-encounters-with-patients-what-physicians-need-to-know

9.2.2. Even without names or personal health numbers, a patient's privacy may be exposed by the clinical uniqueness of a case.

9.2.3. A privacy impact assessment (PIA) should be conducted should AI be introduced to practice.

9.2.4. The practice setting's Securing Personal Health Information Policy should address GenAI if it is used in the practice setting.

9.3. Part of the use of GenAI in documenting care requires these systems to access and review personal health information. Registrants should be aware of what security measures are in place to ensure the information provided to AI systems remains secure and in compliance with existing provincial and federal laws, as well as the patient's preferences. Registrants retain their duty to audit patient records in accordance with CPSM's Standard of Practice for Maintenance of Patient Records in All Settings. Registrants should consult with their IT or cybersecurity expert to ensure that any AI system uses has appropriate data security, confidentiality, and retention protocols.

10. Data sovereignty

10.1. Principles of ownership, control, access, and possession ("OCAP") assert that First Nations have control over data collection processes, and that they own and control how this information can be used. Registrants should consider whether the Securing Personal Health Information Policy within their practice setting is respectful of data sovereignty for Indigenous peoples. The Canadian Institute for Health Information (CIHI) provides some guidance in this area.[17, 18, 19]

11. Health system harm

11.1. Cost overruns and system inefficiency arising from poor data design and use are a material source of harm in the healthcare system. The use of GenAI to support documentation and clinical decision-making has the potential to improve efficiency and access to care while reducing costs. However, it must be carefully evaluated to avoid unintended harm to patients or the uploading of inaccurate or unverified information to provincial databases.

[17] See the Government of Canada's 'Pan-Canadian Health Data Charter' retrieved from https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/pan-canadian-data-charter.html

[18] See CIHI's, 'A Path Forward: Toward Respectful Governance of First Nations, Inuit and Métis Data Housed at CIHI, retrieved from https://www.cihi.ca/sites/default/files/document/path-toward-respectful-governance-fnim-2020-report-en.pdf

[19] See FNIGC's 'The First Nations Principles of OCAP, retrieved from https://fnigc.ca/ocap-training/

12. Patients using GenAI

12.1. People are using GenAI in their personal lives, including for health advice. ChatGPT and other Chatbots have the potential to significantly impact how patients acquire medical information online. This includes to track health statistics, and to help understand signs and symptoms. In some cases, they may wish to bring this information to the attention of their physician. In fact, many GenAI products advise users to review information provided with a qualified medical practitioner. Registrants should be prepared for this to occur more often in practice and should consider a respectful approach to handle the situation.

13. Useful resources

- Health Canada, Artificial Intelligence and Data Act, June 2022.
- Health Canada, Artificial Intelligence and Data Act Companion Document, June 2022.
- Health Canada, Digital Charter Implementation Act, 2022.
- Health Canada, Draft guidance: Pre-market guidance for machine learning-enabled medical devices. September 18, 2023.
- World Health Organization, WHO issues first global report on Artificial Intelligence (AI) in health and six guiding principles for its design and use. June 2021.
- College of Physicians and Surgeons of Alberta, Artificial Intelligence in Generated
- Patient Record Content, 2023.
- CPSBC's Interim Guidance Document regarding 'Ethical Principles for Artificial Intelligence in Medicine
- College of Physicians and Surgeons of Ontario. Can AI Boost Safety and Quality in Patient Care? 2023.
- Canadian Medical Protective Association. The emergence of AI in healthcare, 2019 (revised 2023).
- Federation of State Medical Boards. Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice. Adopted by FSMB House of Delegates, April 2024.
- Law Society of Manitoba. Generative Artificial Intelligence. Guidelines for Use in the Practice of Law. Adopted by the Manitoba Law Society in April 2024.

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR DISCUSSION BRIEFING NOTE

SUBJECT: Advice to the Profession – Point of Care Ultrasound (POCUS)

BACKGROUND:

CPSM has received several concerns from registrants, including radiologists, about the increasing use of point-of-care ultrasound (POCUS) in a variety of clinical settings. Concerns raised include the use of POCUS by registrants who may not have the necessary training or competence, as well as the use of POCUS for clinical issues that require comprehensive diagnostic imaging and specialist interpretation. Examples raised include the investigation of conditions such as ectopic pregnancy and other circumstances where focused ultrasound examinations should not be relied upon as a substitute for comprehensive diagnostic imaging.

Based on the concerns raised, it was determined that registrants would benefit from guidance regarding the appropriate use of POCUS, including its capabilities, limitations, documentation requirements, and the importance of practicing within one's competence.

Development of the Draft Guidance

A physician working group was established to develop the guidance document. The group has been supported by Dr. Ainslie Mihalchuk (Registrar), Mira Bokhaut (Legal Counsel), and Wendy Elias-Gagnon (Communications Director).

The resulting draft, titled **Advice to the Profession: Point-of-Care Ultrasound (POCUS)**, emphasizes that POCUS is a focused clinical tool intended to support immediate clinical decision-making and supplement, rather than replace, comprehensive diagnostic imaging where such imaging is required. The draft outlines expectations regarding competence, clinical use, patient communication, documentation, and the use of POCUS by clinical assistants and physician assistants.

The draft was not finalized as of September 9, 2026 (date meeting materials were provided to Councillors); however, a confidential draft will be provided in advance of the meeting.

For Discussion Briefing Note prepared by: Mira Bokhaut, Legal Counsel

COUNCIL MEETING
SEPTEMBER 23, 2026
COMMITTEE REPORTS
FOR INFORMATION BRIEFING NOTE

EXECUTIVE COMMITTEE REPORT:

On June 26, 2026, a Panel of the Executive Committee heard an appeal of an Investigation Committee suspension decision.

On July 16, 2026, a Panel of the Executive Committee heard 6 appeals of Investigation Committee decisions.

On August 17, 2026, a Panel of the Executive Committee heard an appeal of a Board of Assessor's decision.

The Executive Committee met September 2, 2026. Matters discussed are on the current Council meeting agenda.

Respectfully submitted by
Dr. Charles Penner
President, CPSM and Chair of the Executive Committee

BOARD OF ASSESSORS REPORT:

Since the June 2026 Council meeting, the Board of Assessors has continued to support CPSM's registration mandate by considering complex registration matters and providing input on registration policies and related processes.

The Board's work continues to assist the Registration Department by bringing structured deliberation, public representation, and additional perspective to complex files and policy questions.

The Board's work is always guided, first and foremost, by CPSM's public interest mandate. At it August meeting, the Board considered three registration applications and reviewed changes to four registration policies.

Respectfully Submitted by
Dr. Alewyn Vorster
Chair, Board of Assessors

CENTRAL STANDARDS COMMITTEE REPORT:

CSC Activities since June 24, 2026

- CSC met June 19, 2026.

QUALITY ASSURANCE (QA) AGE-RELATED/REFERRED REVIEWS IN 2025

CSC reviewed:

- 10 New and Repeat QA Age-Related Reviews
- 6 New and Repeat QA Referred Reviews
- 19 New Recognized Training Route/Provisional to Full Reviews

The following outcomes were determined at CSC.

21	#1 Outcomes
7	#2 Outcomes
7	#3 Outcomes
0	#4 Outcomes
0	#5 Outcomes
0	Other – Full Practice Audit, Interactive Audit and More Information Requested
35	Total outcomes

Standards Sub-Committee Reporting

CSC receives 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	Last Report Received
Brandon Regional Health Centre ASC	Prairie Mountain	Dr. Brian Bookatz	18-Aug
Interlake-Eastern ASC	Interlake-Eastern	Dr. Habtu Demsas	22-Jun
Northern ASC	Northern	Dr. Shadi Mahmoud	05-May
Portage ASC	Southern	Dr. Jim Ross	07-Aug
Prairie Mountain Health ASC	Prairie Mountain	Dr. Shannon Prud'homme	14-Apr
Southern ASC	Southern	Dr. Shayne Reitmeier	08-Jun
Boundary Trails Health Centre	Southern	Dr. Kevin Convery	23-Oct-2025
Eden Mental Health Centre	Southern	Dr. William Miller	30-Jul
CancerCare	Provincial	Dr. Chantalle Menard	13-Aug
Endoscopy Provincial	Provincial	Dr. Gerard Coneys	19-Feb-2025
Orthopedic Surgery Provincial	Provincial	Dr. Eric Bohm	03-Jun-2026

Winnipeg Regional Health Standards Committee	WRHA	Dr. Elizabeth Salamon	29-Apr-2024

Cumulative Reporting by Area/Region

The following cumulative report includes total numbers from Quarter 2 reports received from all Provincial Standards Committees and Area Standards Committees for the months of April – June 2026.

			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	Cases Reviewed due to an Adverse Patient Outcomes (APO)	124	119	5			
	Cases Referred because of a concern but not an APO	6					
	Non-APO cases – either routine or randomly selected	29					
	Practice Review or Interactive Review	0					
	Newsletter Item	0					
	Referral to Another Organization	1					
	Number of Meetings in 2026	9					

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

ELECTIONS COMMITTEE REPORT:

The Elections Committee has a scheduled meeting for November 19, 2026 to begin discussions on the 2027 Elections.

Ms. Lynette Magnus was the fourth member of the Committee. However, because she was recently appointed to the Executive Committee and section 4.18.3.b of the Governance Policy prohibits members of the Executive Committee, other than the President Elect, from being on the Committee she is no longer on the Elections Committee. Council has been asked to appoint a replacement at its September 23, 2026 meeting.

Respectfully submitted by
Dr. Kevin Convery
Chair, Elections Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

The Finance Audit & Risk Management Committee (FARMC) met on September 2, 2026. You will find a summary of the meeting and key topics discussed below.

1st Quarter Results

The Finance, Audit and Risk Management Committee reviewed the 1st quarter financial statements for CPSM. CPSM reported a net surplus of $736,575 for the 3 months ended July 31, 2026. Key drivers included increases in revenue of $215,000, primarily in investment income, and a decrease in anticipated expenses of $282,000.

Investment Summary as of July 31, 2026

FARMC received an update and presentation by CPSM's investment advisor. In summary, CPSM's diversified portfolio navigated market dynamics effectively in 2026, generating positive returns while maintaining a balanced risk profile aligned with its investment objectives.

The composite return on CPSM's portfolio was 3.1% for the first quarter which exceeded the anticipated return.

Audit Debrief - 2025/26

A debrief meeting between CPSM Management and BDO Auditors took place in July 2026, aimed to enhance communication and alignment for future audits, addressing challenges like the compressed year-end period.

Financial Impacts 2026/27 & 2027/28

Management provided a document outlining potential future negative revenue and expense impacts for 2026/27 & 2027/28.

The total estimated financial impact is $578,000 in 2026/27 and $287,100 in 2027/28. While the 2026/27 impact could be absorbed within the current year's resources, further review is required to assess ongoing revenue losses and expenses beyond the current fiscal year. Management will be closely monitoring the potential impacts with the intention to mitigate the impact on CPSM's financial picture.

Risk Review – Cybersecurity Update

CPSM's IT Manager, Sam Lount presented the latest developments related to cybersecurity and how CPSM is improving its cybersecurity posture. With a CIS score of 60%, which is considered a good score for organizations of CPSM's size, areas that will benefit from improvement are; software engineering, data sensitivity labelling and environmental changes. Recognizing human error as the greatest vulnerability, CPSM is reinforcing cybersecurity awareness through phishing simulations, training videos, and incident response exercises.

Office Space - Request for Proposal

Management will be seeking proposals from commercial real estate firms to evaluate leasing versus purchasing office space for its long-term accommodation needs. With its current lease expiring in 2031, CPSM aims to assess whether renewing the lease, securing a new lease, or looking acquiring an office building would best serve its requirements over the next 15-25 years.

Reserve Review and Terms of Reference
Management provided environmental scans on both the current Wind-up reserve as well as the committees terms of reference. The Committee after review agreed to maintain the current wind-up reserve as well as the terms of reference.

Respectfully submitted by
Dr. Kevin Convery
Chair, Finance, Audit & Risk Management Committee

INQUIRY COMMITTEE REPORT:

In June 2026, there was and inquiry hearing for Dr. E. Minuk where the inquiry panel approved a joint recommendation of the CPSM Legal counsel and Dr. Minuk's legal counsel. This decision has been published.

There will be another inquiry for Dr. D. Gill in November 2026. The panel for this hearing has been completed and are in the process of working on the procedural steps for this hearing.

Respectfully submitted by
Dr. Nader Shenouda
Chair, Inquiry Committee

INVESTIGATION COMMITTEE REPORT:

Since the last reporting, the Investigation Committee met June 10, 2026, August 5, 2026, August 19, 2026. An upcoming meeting is scheduled for September 9, 2026.

On June 8, 2026, a panel was assembled to discuss the lifting of a physician's suspension.

At the June 10. 2026 meeting, ten cases, two dismissals and three procedural closures were reviewed, resulting in the following:

- Letter of Criticism & Opening of an Audit - 1
- No Further Action - 3
- Undertaking -2
- Informal Resolution - 1
- Procedural Closure - 3
- Dismissal Upheld - 2

At the August 5, 2026 meeting, eleven cases, three dismissals and one procedural closure were reviewed, resulting in the following:

- Letter of Criticism - 6
- Letter of Advice - 1

- Undertaking - 1
- Referral to Inquiry - 1
- Procedural Closure - 1
- Dismissal Upheld - 3

A Special Meeting was held August 19, 2026 to discuss three related cases with the following outcomes:

- No Further Action - 3

An orientation was provided to the new IC members on June 19, 2026.

A session was provided to the Investigation Committee members on good Governance, including tips for Investigation Committee Panel Chairs and members and key pointers for panels. The feedback received from the presentation was positive.

As of September 1, 2026, there are 245 open investigations.

Respectfully submitted by
Dr. Jennifer McNaught
Chair, Investigation Committee

PROGRAM REVIEW COMMITTEE REPORT:

Nothing further to report since the June 23, 2026 CPSM Council meeting.

Next PRC meeting is set for September 9, 2026.

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

COUNCIL MEETING
SEPTEMBER 23, 2026
FOR INFORMATION BRIEFING NOTE

SUBJECT: Council Training – Governance Basics for a Regulatory Body

BACKGROUND:

As previously discussed at the December 10, 2025 Council, a highly functioning Council requires its members have a comprehensive understanding of the roles, responsibilities, and best practices for nonprofit regulatory councils. The training topics agreed upon as being beneficial were Governance in Action, Integrated Risk Management, and Cyber Security.

A training session for Integrated Risk Management occurred at the June 24, 2026. The next training session will occur at this Council for Governance in Action, the two-hour session will be facilitated by Ms. Judy Murphy | CEO | Murphy's Executive Leadership Coaching and Consulting, biography is attached as ***Appendix A***.

Please see the attached (***Appendix B***) pre-reading material of Governance Basics in a regulatory context for the September 23rd Council training session.

For Information Briefing Note prepared by: Ms. Sherry Dupuis, Executive Director, People and Culture

YOUR CONSULTANT

Murphy's Executive Leadership is dedicated to equipping you and your board or teams with the tools and skills you need so you can perform at your best, feel confident and maximize your individual and collective impact on the world. We accomplish that through supporting organizations in board governance, strategic planning and executive and team coaching.

Judy Murphy

Judy draws on her nearly three decades of on-the-ground experience gained from multiple perspectives: CEO, Board Director, Consultant and Coach. Judy's clients include not-for-profit organizations, for-profit companies, Provincial Crowns and Agencies and post-secondary institutions. Judy has also worked extensively with self-regulated bodies including CPA Manitoba and CPHR Manitoba both in board development and strategic planning.

She is the owner of Murphy's Executive Leadership. Previously, she was President & CEO of Safety Services Manitoba and Practice Leader for Strategy and Governance for MNP. She has held executive leadership positions in three other organizations. She also teaches Ethical Behaviour for the Certified Management Consultants of Canada. Judy taught Organizational Behaviour for the University of Winnipeg's PACE Programs for six years.

Boards

She is currently Chair of the St. Boniface Hospital and the Vice-Chair of the Reh-Fit Centre where in both organizations she previously chaired the Governance and Nominating Committee. She was also previously the external member for the Finance, Audit and Risk Committee of Doctors Manitoba. She has previously been the Chair of both the Manitoba and Winnipeg Chambers of Commerce, a Board Director and Finance and Audit Committee Chair for the Crown Corporations Council of Manitoba and for the Manitoba Centennial Centre Corporation. She was previously a member of the Premier's Economic Advisory Council where she chaired three task groups.

Judy brings expertise and depth of experience in:

- Board Governance
- Team Development (Insights Discovery and Myers Briggs);
- Strategic and Operational Planning; and
- Systemic Team Coaching and Executive Coaching.

Designations and Credentials

- Certified Management Consultant (CMC)
- FCPA, FCA (Institute of Chartered Accountants of Manitoba)
- ICD.D (Designated Corporate Director; Institute of Corporate Directors/Rotman School of Business – University of Toronto)
- BA (University of Manitoba)
- CPHR (Chartered Professional in Human Resources)
- Certified Executive Coach (Royal Roads University)
- Accredited Systemic Team Coach Practitioner (European Mentoring and Coaching Council)
- Accredited Executive Coach (International Coach Federation)
- Licensed Practitioner for Insights Discovery
- Certified in Enneagram Studies with Russ Hudson and Jessica Dibbs
- Certified Trainer in Resilience at Work for individuals, leaders and teams
- Certified practitioner in Myers Briggs Typology and Emotional Intelligence 2.0 Clients

Governance Basics for a Regulatory Body

A practical guide for council members

1. The Purpose of Governance

Governance is how an organization makes decisions, who has authority to make them, and how accountability is demonstrated. In a regulatory body, governance has an added public-interest dimension: the Council must ensure the organization fulfills its mandate to protect the public, uphold standards, and maintain trust in the profession or sector it regulates.
A regulatory council does not run the organization day to day. Its role is to see to it that the organization achieves its purpose, remains sustainable, acts ethically and responsibly, and operates within the authority granted by legislation, bylaws, and policy. A useful shorthand is: **noses in, fingers out**. Council members should be deeply curious, well informed, and prepared to ask strong questions, while leaving implementation and operations to management.

2. Core Duties of Council Members

Council members are legal guardians of the entity. They make decisions on behalf of others and exercise authority that comes from statute, bylaws, regulations, and Council-approved policies. Their responsibilities are collective: individual members contribute questions, judgment, and expertise, but the Council speaks through its decisions as a whole.

- **Duty of care:** Be informed, prepared, diligent, and attentive. Read materials, understand the issues, ask questions, and ensure decisions are based on reasonable information.
- **Fiduciary duty:** Act honestly, in good faith, and in the best interests of the organization and its public-interest mandate, not in the interests of a single stakeholder group.
- **Duty of loyalty and integrity:** Identify, disclose, and manage actual, potential, or perceived conflicts of interest. Refrain from influencing decisions when appropriate, leave deliberations when required, and ensure the conflict-management steps are recorded.
- **Collective accountability:** Support the integrity of Council decisions once they are made, even when healthy debate occurred before the vote.

Good governance is supported by documented policies and processes, meeting preparation, insurance and indemnification, healthy board dynamics, due diligence, and an understanding of the organization's stakeholders and operating environment.

3. The Regulatory Context

Regulatory bodies exist to serve and protect the public. They set and monitor standards, oversee entry to practice, support continuing competence, address complaints and discipline, and maintain public confidence in the profession. This means the Council must balance multiple interests while keeping the public interest at the centre of every decision. For members who are also practicing professionals, the shift can be significant. At the Council table, members are not there to represent their own practice area, region,

colleagues, or personal experience. They bring that knowledge to the discussion, but their duty is to the organization's mandate and the public interest.

4. Council Work: Oversight, Insight and Foresight

Councils add value when they do more than review the past. Effective governance includes hindsight, oversight, insight, and foresight. Hindsight reviews what has already happened. Oversight monitors performance, compliance, finance, and risk. Insight asks what the information means. Foresight looks ahead to emerging risks, public expectations, workforce trends, technology, trust, and changes in the profession or sector.

Council Focus	Key Question
Purpose and mandate	Are we protecting the public and fulfilling our statutory purpose?
Strategy	Are we focused on the right long-term outcomes?
Risk	What could affect our ability to meet objectives or preserve trust?
Performance	How do we know the organization and CEO are achieving expectations?
Culture and ethics	Are our values reflected in decisions, behaviour, and tone at the top?

5. The Council–Management Relationship

The Council delegates authority to the CEO or registrar and remains accountable for how that authority is used. Management is responsible for operations, staffing, program delivery, administration, and implementation. The Council is responsible for direction, boundaries, oversight, risk appetite, CEO evaluation, and ensuring the organization remains aligned with its mandate.

The relationship should be respectful and clear. The Council needs concise, relevant information from management; management needs clarity about expectations, authority, and decision rights. Healthy tension is normal. It becomes productive when roles are clear, questions are focused on governance issues, and both Council and management assume positive intent.

6. Appeals, Hearings and Regulatory Decision-Making

In regulatory bodies, Council members may have roles related to appeals, hearings, discipline, registration reviews, or other statutory decision-making. These roles must be approached with fairness, independence, procedural discipline, and respect for the governing legislation and policies.

- Understand whether you are acting as a governor, an adjudicator, or both in different contexts.
- Follow the process set out in legislation, bylaws, terms of reference, and policy.

- Approach each matter with an open mind and avoid prejudgment.
- Rely on the evidence and record before the decision-maker.
- Manage conflicts of interest and perceived bias carefully.
- Respect confidentiality and the privacy of parties involved.
- Ensure reasons, decisions, and minutes are appropriately documented.

The key discipline is to keep the governance role and adjudicative role distinct. A Council may set policy and oversee the effectiveness of the regulatory framework, but individuals involved in hearings or appeals must protect the fairness and independence of the specific process.

7. What Effective Council Members Do

- Come prepared, read the materials, and identify the governance questions in advance.
- Ask questions that test assumptions, clarify risk, and connect decisions to purpose.
- Challenge ideas, not people.
- Listen for what is in the public interest, not only what is operationally convenient or professionally familiar.
- Respect the difference between Council work, committee work, staff work, and adjudicative work.
- Support decisions once made and speak with one Council voice.
- Participate in board evaluation, learning, and continuous improvement.

8. Questions to Keep the Council in the Right Lane

- What decision is being asked of the Council, and is it a governance decision?
- How does this advance the public-interest mandate?
- What are the most important risks, and how are they being mitigated?
- What assumptions underlie management's recommendation?
- What alternatives were considered, and why were they rejected?
- What information would help us make a more informed decision?
- How will we know whether this decision achieved the intended result?

9. Closing Thought

Good governance is not about having all the answers. It is about asking the right questions, staying in the right role, making decisions with integrity, and keeping the public-interest mandate at the centre of the Council's work.