December 2021 Council Meeting

Wednesday, December 8, 2021 @ 8:00 a.m.

AGENDA

CPSM Brown Room

	Time	Item		Action	Presenter	Page #
8:00 am	5 min	1.	Opening Remarks		Dr. Elliott	
8:05 am	0 min	2.	Agenda	Approval	Dr. Elliott	
8:05 am	0 min	3.	Call for Conflict of Interest		Dr. Elliott	
8:05 am	5 min	4.	Council Meeting Minutes September 29, 2021	For Approval	Dr. Elliott	2
8:10 am	30 min	5.	Standard of Practice Documentation in Patient Records and Standard of Practice Maintenance of Patient Records	For Approval	Mr. de Jong	8
8:40 am	30 min	6.	Standard of Practice Office Based Procedures	For Approval	Dr. Convery	71
9:10 am	60 min	7.	Complaints/Investigations Restructuring	For Information	Dr. Bullock Pries	190
10:10 am	10 min	8.	Complaints/Investigations Practice Direction	For Approval	Dr. Bullock Pries	202
10:20	20 min	9.	--- Break ---			
10:40 am	10 min	10.	Standard of Practice Exercise Cardiac Stress Testing	For Approval	Dr. Suss	220
10:50 am	5 min	11.	Financial Management Policy	For Approval	Dr. Shenouda/ Mr. Rubel	226
10:55 am	5 min	12.	Strategic Organizational Priorities Progress Tracking	For Information	Ms. Kalinowsky	236
11:00 am	15 min	13.	Registrar/CEO Report	For Information	Dr. Ziomek	237
11:15 am	15 min	14.	Committee Reports (written, questions taken) Executive Committee Finance, Audit & Risk Management Committee Complaints Committee Investigation Committee Program Review Committee Central Standards Committee	For Information		244
11:30 am	30 min	15.	In Camera – with Registrar In Camera – Council Only Review of Evaluation of Council			244
4 hrs			Estimated time of sessions			

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MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on September 29, 2021, via ZOOM videoconference.

1. CALL TO ORDER

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

COUNCILLORS:

Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Mr. Chris Barnes, Assoc. Member
Dr. Kevin Convery, Morden
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Ravi Kumbharathi, Winnipeg
Ms Lynette Magnus, Public Councillor
Dr. Wayne Manishen, Winnipeg
Dr. Norman McLean, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Charles Penner, Brandon
Ms Leanne Penny, Public Councillor
Dr. Brian Postl, Winnipeg
Dr. Mary-Jane Seager, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg
Dr. Heather Smith, Winnipeg
Dr. Roger Süss, Winnipeg
Dr. Anna Ziomek, Registrar

REGRETS:

Dr. Daniel Lindsay, Selkirk
Dr. Ira Ripstein, Winnipeg

STAFF:

Dr. Ainslie Mihalchuk, Assistant Registrar
Dr. Karen Bullock-Pries, Assistant Registrar
Ms Kathy Kalinowsky, General Counsel
Mr. Dave Rubel, Chief Operating Officer
Dr. Marilyn Singer, Quality Improvement Director
Ms Karen Sorenson, Executive Assistant
Ms Lynne Leah, Executive Assistant
Ms Jo-Ell Stevenson, Manager, Registration
Ms Wendy Elias-Gagnon, Communications Officer

2. ADOPTION OF AGENDA

IT WAS MOVED BY Dr. Roger Suss, SECONDED BY Dr. Eric Sigurdson:
CARRIED:

That the agenda be approved with the addition as a final item “Consultation for Standard of Practice for Patient Records to be reviewed and commented on by the Central Standards Committee.”

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Jacobi Elliott called for any conflicts of interest to be declared. There being none, the meeting proceeded. Similarly, there was no request for an in-camera session.

4. ADOPTION OF MINUTES

IT WAS MOVED BY DR. ROGER SUSS, SECONDED BY DR. NADER SHENOUDA:
CARRIED

That the minutes of the June 9, 2021, meeting be accepted as presented.

5. STANDARD OF PRACTICE - VIRTUAL MEDICINE

A Strategic Organizational Priority, the Standard of Practice for Virtual Medicine was revised after significant feedback was received from the public), members, and stakeholders. The general provision was revised to provide additional clarity and focus on the blended model of in-person and virtual medicine. Each members' practice of medicine must include timely in-person care when clinically indicated or requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. ERIC SIGURDSON:
CARRIED

That the Standard of Practice for Virtual Medicine, as attached, is approved, to be effective November 1, 2021.

6. STANDARD OF PRACTICE - EXERCISE CARDIAC STRESS TESTING

Exercise Cardiac Stress Testing poses sufficient risk of potential harm to a patient to require specific standards of practice to be adhered to by those members supervising this test. A diverse Working Group of cardiologists, both in the hospitals and in the community, have met to prepare a draft Standard of Practice for Cardiac Stress Testing.. This Standard will apply for all exercise stress testing, whether in private facilities, accredited non-hospital medical and surgical facilities, and hospitals or other health authority facilities.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. MARY-JANE SEAGER:
CARRIED

That the Standard of Practice Exercise Cardiac Stress Testing, as presented, be approved for consultation with the public, stakeholders, and registrants.

7. TRUTH AND RECONCILIATION – ADDRESSING ANTI-INDIGENOUS RACISM BY MEDICAL PRACTITIONERS

At its meeting in June, Council established Truth and Reconciliation – Addressing Anti-Indigenous Racism by Medical Practitioners as a Strategic Organizational Priority. It is important that this priority be led by and informed by indigenous physicians, indigenous members of CPSM, and indigenous community members and that this be an Advisory Circle, not a Working Group. The Terms of Reference for the Medical Practitioners Advisory Circle were presented to Council for approval.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. MARY-JANE SEAGER:
CARRIED

That Council approves the Terms of Reference for the Truth & Reconciliation – Addressing Anti-Indigenous Racism by Medical Practitioners Advisory Circle.

8. PRESCRIBING PRACTICES REVIEW

The Terms of Reference for thePrescribing Practices Strategic Organizational Priority were reviewed. Prescribing changed dramatically with COVID-19, and the review will determine whether some of the changes will be made permanent. In addition they will be reviewing the M3P practice for prescribing. This is to be a joint working group with the Colleges of Pharmacy and Registered Nurses.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. BRIAN POSTL:
CARRIED

That the Terms of Reference for the CPSM Prescribing Practices Review, be approved as attached.

9. STANDARD OF PRACTICE FOR EPISODIC CARE/HOUSE CALLS/WALK-IN CLINICS

The Terms of Reference were reviewed. This Strategic Organizational Priority will set the minimum standard of care for those who practice primary care in this model and will address continuity of care and follow-up requirements.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MR. CHRISTOPHER BARNES:
CARRIED

That the Terms of Reference for the Standard of Practice for Episodic Care/House Calls/Walk-In Clinics working group be approved as attached.

10. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

Councillors were presented with the Progress Chart for the Strategic Organizational Priorities and progress.

11. STANDARDS SUBCOMMITTEES GUIDE FOR OPERATIONS HANDBOOK-for information

Councillors were presented a Guide for Operations handbook recently prepared to facilitate consistency and standardization in approach and deliberation around the activities of Standards sub-committees as well as outcomes, data collection, and reporting, with the goal of enhancing CPSM's supervision of the profession of medicine. The handbook contains helpful guidance on the following:

- Formation and meeting frequency
- Process for selection and review of cases
- Decision and disposition of cases
- Data collection, reporting and communication between subcommittees and Central Standards Committee
- Tools and Resources

12. ACCREDITED FACILITIES & STANDARD COMMITTEES

With the move of the Accredited Facilities oversight to the Program Review Committee, the development of the adverse patient outcome reviews, and the difficulty of performing meaningful peer review of small facilities, there is no requirement for a Standards Committee for each accredited facility.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS. DOROTHY ALBRECHT:
CARRIED

That the following Standards Committees are deleted from Schedule C of the Central Standards Bylaw:

Assiniboine Surgical Centre Standards Committee
Ageless Cosmetic Clinic Standards Committee
First Glance Aesthetic Clinic Standards Committee
Heartland Fertility & Gynecology Clinic Standards Committee
Manitoba Clinic Endoscopy Suite Standards Committee
Maples Surgical Centre Standards Committee
Visage Clinic Standards Committee
Women's Health Clinic Standards Committee
Western Surgery Centre Standards Committee
Winnipeg Clinic (Endoscopy) Standards Committee

13. CEO/REGISTRAR'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at the College. Dr. Ziomek spoke verbally to this report and answered the questions presented by Councillors. Discussion ensued on the planned Governance session for Council and the changes to the Complaints and Investigations Committees and department.

14. COMMITTEE REPORTS

The following Reports were presented to Council for information:

- Executive Committee
- Audit & Risk Management Committee
- Complaints Committee
- Investigation Committee
- Program Review Committee
- Quality Improvement Committee
- Standards Committee

15. CONSULTATION PROCESS FOR STANDARD OF PRACTICE FOR PATIENT RECORDS

IT WAS MOVED BY DR. HEATHER SMITH, SECONDED BY DR. CHARLES PENNER:
Carried

Further discussion on this matter was tabled to the In Camera session.

16. IN CAMERA SESSION

An in-camera session was held, and the President advised that Council wants Restructuring of Complaints and Investigations to be a Strategic Organizational Priority recognizing it is not just operational. The President also advised of this motion:

IT WAS MOVED BY DR. ROGER SUSS, SECONDED BY DR. MARY-JANE SEAGER:
Carried

That Council send the current draft Standard of Practice for Documentation in Patient Records and the draft Standard of Practice for Maintenance of Patient Records to the Central Standards Committee for feedback.

The President also advised that the Registrar is to attend the first part of the in-camera session in future Council meetings.

There being no further business, the meeting ended at 12: 47 p.m.

_____
Dr. J. Elliott, President

_____
Dr. A. Ziomek, Registrar

DECEMBER COUNCIL MEETING
DECEMBER 8, 2021
NOTICE OF MOTION FOR APPROVAL

TITLE OF DRAFT STANDARDS:

1. Standard of Practice for Documentation in Patient Records
2. Standard of Practice for Maintenance of Patient Records

OUTCOME SOUGHT:

Approval by Council of these Standards of Practice.

BACKGROUND:

On June 9, 2021, Council approved a motion to distribute draft Standards of Practice for Documentation in Patient Records and Maintenance of Patient Records. The public consultation has now concluded. This is a Strategic Organizational Priority.

PUBLIC CONSULTATION:

CPSM received 19 useful and diverse responses to its public consultation. This includes responses from members, government, and other regulators. Responses were received from the CMPA (Canadian Medical Protective Association), Doctors Manitoba, and other members of the public. Attached are responses obtained through public consultation.

REVISIONS:

Attached are versions of the draft patient records standards with tracked changes approved by the working group following the public consultation. Also attached are clean copies of the revised draft patient records standards (tracked changes accepted).

The working met on August 16 and 26 to discuss the public consultation.

Not all suggestions or requests from the public consultation resulted in revision by the Working Group, though some comments did result in modification.

1. **Documentation in Patient Records Standard**:

The majority of responses sought additional explanation respecting provisions of the draft Standard. Thus, clarifications were added, as well as explanatory footnotes.

Questions were raised in the consultation about documentation of advice or consultation in situations where members are on call or acting in a consultant capacity (e.g., providing medical advice

in real time to other health care professionals, including paramedics, with no direct patient contact). A significant addition to the Documentation Standard for this scenario was added (see paragraph 2.19). The Working Group does not consider it necessary for another public consultation to take place despite this significant addition, though Council should approach this provision with special scrutiny in that context.

- It is noted the Executive Committee previously considered this addition (2.19) and sent it back to the working group for reconsideration. While the working group was of the view the original wording reflected the prevailing standard of practice in the profession, revisions were made considering concerns raised by the Executive Committee. The working group remains of the view that inclusion of guidance in this area in the draft standard is advisable.

One request from the public consultation was to add a requirement that disclosures of personal health information, such as transfers of patient records, be documented. This was seen as a prudent measure. Such documentation would be considered an added safeguard for the confidentiality of patient information. However, the group decided not to make this a requirement. Rather, it was thought this is more an area for government to address if it sees fit through its administration of *The Personal Health Information Act*.

It was recommended a requirement that members engage in periodic PHIA training be added to the Standards, which was noted to already be a requirement in institutional settings. The working group determined advice that members should keep current would suffice.

Other notable recommendations related to the requirement that documentation be in English, the need to document sex or gender, and the need to document an emergency contact. These were areas of debate and controversy. It is acknowledged the English requirement does limit expression, though English is the only language in which all health care workers are required to be fluent, the system is not equipped to handle a multitude of languages, and the limit is considered pragmatic and justified.

2. Maintenance of Patient Records Standard:

As with the Documentation Standard, most respondents sought additional explanations. Thus, clarifications were added, as well as explanatory footnotes. Several organizations recommended CPSM to develop standard wording and templates for documents that we require. This was already contemplated before the public consultation and will be done in advance of the Standard coming into force. To that end, it is recommended the Standard come into force no earlier than February 2021.

Our notice that electronic patient records linked to provincial systems will be required when the Standard is reconsidered in 2026 attracted significant response. Issues included:

- What precisely is meant by linked?
- Will the membership be supported in the transition?
- Consultation with Digital Health should take place well in advance.

These are matters that will need to be carefully considered by the Council and CPSM moving forward, though need not be directly addressed at this time.

Abandoned patient records:

Little response came respecting our proposed measures to avoid abandoned patient records. However, the Working Group did reassess this area of the Standard for improvement. In that regard:

- A definition of an abandoned patient record was added.
- Additional information was added about practice trustees and estate planning.
- A limitation was made on to whom responsibilities may be transferred.

For background respecting the additions, where patient records form part of the estate of a member who has died or has become incapacitated (e.g., guardians, executors/administrators), the law requires that the personal representative safeguard those patient records (but not PHIA unless the personal representative happens to be a trustee as the term is defined in PHIA). For example, the estate trustee of a member who has died and was the owner and trustee of patient records has a fiduciary duty to safeguard those records and ensure patient access rights, at least until custodianship of the patient records is transferred to another appropriate trustee.

It is unclear to CPSM whether the specific obligations to safeguard personal health information and ensure enduring patient access which apply to trustees as defined under the *Personal Health Information Act* apply equally to personal representatives who do not meet the definition of trustee under PHIA. CPSM certainly has no jurisdiction over non-members who become the personal representative of a member or former member, and therefore cannot govern how that non-member maintains impacted patient records. Thus, the working group was of the view this eventuality should be avoided.

To best ensure proper compliance with PHIA requirements regarding patient records created by members, this Standard now requires a succession plan that involves transfer of custodianship to a member of CPSM or trustee who engaged or employed the transferring member.

The plan may require a power of attorney (for incapacity) or a will (for death) respecting the appointment of practice trustee. The working group noted the ideal would be for a local hospital or regional health authority to take over custodianship in respect to sole practitioners. Government should be approach on this point, subject to concurrence from Council. It is noted draft legislation from government not yet brought into force suggest CPSM should take custody of patient records. CPSM has no infrastructure for this purpose.

Other comments

Concern was raised about situations where a clinic that is owned by a non-member becomes trustee of a member's medical records (e.g., a health care facility owned by a private company or another person, such as a pharmacist). This should be mitigated by the need for a robust maintenance agreement. A note in the draft Standard cautions against these arrangements.

The working group questioned whether CPSM should prohibit maintenance arrangements with trustees outside their practice setting or group practice where chart is actively being used (e.g.,

another clinic). It determined this complex issue should be considered at another time with further consultation with stakeholders.

PUBLIC INTEREST RATIONALE:

"A College must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." s. 10(1) RHPA (Regulated Health Professions Act)

Medical record keeping skills are a core component of good care and essential to effective regulation of the profession. Complete and accurate patient records are particularly important to:

1. maintenance of the expected standard of care over time,
2. ensuring other members or health care professionals can act on significant information in the patient record as and when required, and
3. facilitating meaningful review or audit of the care provided by others, including by CPSM and other authorized health authorities when required.

The Documentation in Patient Records standard support the above factors.

Members are required to safeguard and keep confidential their patient's personal health information. The specific requirements of the maintenance standard support this important ethical and professional requirement.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 8, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

1. Council hereby approves the Standard of Practice for Documentation in Patient Records as attached to be effective February 15, 2022.

2. Council hereby approves the draft Standard of Practice for Maintenance of Patient Records as attached to be effective February 15, 2022.

3. Council hereby rescinds the current Standard of Practice for Patient Records on February 15, 2022.

Comment
CPSM Members
Reviewed/Agreed, no objection. Thanks!
The addition of this new statement is long overdue. As you are aware, some of your members, I included, have struggled to provide safe, continuous care to our patients due to the College's inability/reluctance to ensure that we as physicians have rights and access to our patients' medical information in order to provide quality care. As this is an ongoing issue I continue to deal with in my practice, I hope that this standard will achieve what the College was set out to do in the first place - protect our patients. My feedback as a provider who does not have reasonable access to the patient records I created for the patients who have always been, and continue to be under my care, is as follows: in 4.7, and 4.22: it asks that I can reasonably access/produce records: what does this mean exactly? In my opinion, I cannot comply. I should be able to access the information I entered into the EMR for all my patients by looking them up in my current EMR/record, but I cannot. I would need to gain access by going to the clinic that has this information, request it, and wait. Also 5.6 - charging a fee - according to PHIA (which I updated recently), the purpose of trustees is not to be able to charge for copying/transferring patient information (this was actually listed as a multiple choice answer - but was not the correct answer), yet the College states it's OK to charge - also, what fee is reasonable? $100,000? I also would like to know how you will actually ensure these standards are met by your members. As it stands, I have been unable to comply with rules already outlined by the College/PHIA (for example, responding to a hospital's request for information for a hospital in patient within 24 hours) because I don't have reasonable access to my patients' record (that I created) - and there has been nothing the College has been able to do about this, despite formal complaints and a College mediator.
I had a number of comments about the proposed documentation in patient records standards as pertains to a Medical clinic. I have been very involved in our EMR from our conversion from paper charts in 1999 and through a conversion from Clinicare to Accuro. Patient identification and contact information - in 2.6.2 it says an emergency contact person must be collected and documented. I think this is rarely done and I do not see the purpose or practicality of this for all patients or when you would usually use it. (in a clinic setting) We have a right to access form where it lists people, usually family members that we can contact about our patient. Under PHIA we are not allowed to discuss issues about a patient with family members without a patients consent. If we were to put an emergency contact then that would need to be regularly updated. It is hard enough to get accurate information from patients about current phone numbers and addresses. Staff are to confirm at each visit but the patient often will say no changes when there have been. In the rare occasion you might want to use this the info may be inaccurate. Date and time of entries 2.15.2. - I am not sure of the purpose to write that the entry is a late entry in a EMR as each entry is date and time stamped in the legal record. You may not have time to enter notes immediately and may do some notes a week or more later. Alterations 2.16 - this point should distinguish better between paper records and electronic records.. It says original records must not be altered. I do not see this as practical in an EMR. It also says records

should be dated and signed, should this not be just for paper records. In a paper record if there is a correction you put a line through the entry and write above it and sign and date.
In a electronic record you may need to change something such as an incorrect word. I think some systems are set that you cannot change the record and need annotate changes at the end. In a lot of systems I think you can correct the error, and the record of changes are in the legal record. If we open an encounter note we can easily see what previous versions look like by going to tools.
I use voice recognition software to enter notes and try to be sure it is accurate but often enough at their next visit I notice a word is incorrect and would not make sense for other people looking at the record and so I change it.

Cumulative summary of care 3.5.8 - says Immunizations - the record will have any immunizations given in our clinic in the summary. Immunizations given elsewhere are on EChart and easily found. You can manually enter other immunization but this would be very time consuming. The way this is worded could imply that you feel that immunizations given elsewhere should be added to the record.

I would be happy to discuss these in more detail if necessary as data quality in the EMR is something I am very interested in.

Currently, should I experience a precipitous cessation of practice, my medical records would become abandoned.
I have not been able to recruit help from Doctor's Manitoba in this matter.
Neither has my EMR provider offered any advice, Except to state that in British Columbia there exists an agency, That can store and dispense medical records.

2.14 English may be the predominant language of charting, but there may be instances where indigenous or other people group languages, ideas, terms, may better reflect the patient's experience and should not be excluded from the patient record, based solely on language, where the reasonable understanding of the chart note is not impaired by the use of alternate languages. I feel this is a euro-centric, colonial approach to governance that does not respect the essence of reconciliation.

re: Page 2, Notice : -Can you clarify what is meant by the expected requirement by 2026 to " link" to provincial systems such as dpin, echart etc? Currently we have internet access to search these systems for needed information, and will scan documents to add to our office EMR. I dont consider this "linked", please elaborate what will be required.

re page 5, maintenance agreement: is it possible to include an example of a maintenance agreement, to make clearer the degree of detail that is expected? The requirement of a written agreement is clear, however not how we are actually supposed to do this.

A few suggestions based on chart audits I have done.

11 (1). I think for clarity this should not just say documentation of patient care provided. It should also say something like" and the information that formed the basis for the care provided". I have audited charts where they say what the care provided was. Ie. "rx'd penicillin ". And they would argue they

documented care given. I know later on in the standard it is spelled out but I think to be more inclusive in this area would set the scene.

2.5. This should say virtually or in person. I believe a call to a patient should be recorded in the appointment list as well as being recorded in the medical record just like an in person visit. (this is supported in your virtual care standard). Rarely have I done audits where this is consistently done. Not recording these calls leaves holes in care. It leaves you wondering if the patient was notified about something. I think the record keeping standard needs to be clear on the importance of this.

2.8.2. Macros. Lots of trouble with these on audits. I think that it should be clear that any portion of a macro that doesn't apply or wasn't addressed should be deleted. Otherwise you have lists of irrelevant symptoms for example that you are not clear what are doing there. (perhaps there should be a special licence to allow you to use macros! Just kidding) I am sure you know the issues. (does everyone in a family doctors office need a Glasgow coma scale assessment! Only if the macro says you do). They so need to be pointed and reflect what was done at that visit and only that.

2:12. Should this include recording what is sent by text message from patients as well. No matter how often I have asked them not to do this important critical health information gets sent in this format from time to time. I am sure I am not the only one. Clarity on this would be helpful.

I think it might be helpful to add a little more guidance on what to record when releasing information to the patient or others. I think we should be saying that when information is released (following PHIA of course) you need to record when,to whom and what exact parts of the records were released. It becomes important if a correction to the information needs to be made because my understanding is we need to communicate that correction with everyone we shared the incorrect information with according to PHIA. Correct?

the issue of abbreviations is a challenge with emr as the abbreviations are built into the prescribing programs of the emr and can't be modified. Don't know if you can address this in what is expected of an emr. Many of the abbreviations in the program are ones we are not to use.

Thanks for all this work. It is important that the expectations are clear and published so when I am discussing records I have something to reference.

Thank you for the opportunity to review the upcoming Standards of Practice regarding the Maintenance of Patient Records.

I only have a question regarding the notice about EMRs linked to provincial government electronic medical records systems. Although some EMRs have a direct link to such services, some clinics access this information, not through the EMR, but directly via eChart. Would this be considered to meet the standard of care suggested?

4.20. In accordance with subsection 11(3) of the Standards Regulation, members must ensure patient records are retained for a minimum of the following time periods:
4.20.1. Respecting adult patients, 10 years from the date of the last entry in the record.
4.20.2. Respecting patients who are children (i.e., minors), 10 years after the day on which the patient reached or would have reached 18 years of age.

4.21. In accordance with subsection 10(2) of the Standards Regulation, members must ensure the record of appointments kept for their practice is retained for at least 10 years after the date the record was made.

I definitely believe the retention time must be revised. Holding patient records for 10 years is excessive. In my experience as a family physician, when patients want their records transferred to a new physician they generally do so within the first year. I have yet to see anyone request their chart years later.
Additionally, re: 4.20.2. Take for example an infant that changes their practitioner at 1 year of age. That means that practitioner would have to keep their records for 27 years. 27 years!!! I don't know about you, but that is most definitely excessive. How are pediatricians supposed to maintain these records? Most would be expected to retain these records well after they retired/passed on.
Additionally, a very important point must be addressed in the preamble. And that is consideration given to pitfalls in drafting the SOP. You see, there are those in the College that work primarily or even exclusively in an institutionalized setting. As such they bear no responsibility in maintaining patient records. I would hope that it was an unintentional oversight among the administration that drafted these rules. It is not fair to expect practitioners participating in community care in a non-institutionalized setting to pay extreme fees to an EMR to maintain/access their records. These EMR's generally have a monopoly on records and it costs thousands of dollars to keep a "subscription." Yet, with these rules retired physicians would have to pay for 10+ years of a subscription (which is the same fee as if you're practicing), which would cost thousands if not tens of thousands of dollars.

My recommendation: Shorten the retention period to no greater than 5 years for both adult and pediatric populations after the date of last entry in the record. Additionally, consideration should be given for compensation for practitioners who have to maintain these records. Either perhaps the CPSM should pay for these costs or perhaps some type of rebate system should be implemented.

I hope this information guides you well in your draft.

Public

I have read the draft provided here:
https://cpsm.mb.ca/assets/Consultations/PatientRecords/SoP%20Patient%20Records_Consultation.pdf

I'd like to provide more comment but I have been unwell, and I am experiencing difficulties trying to form the below comments. I appologize if my grammer or elaboration is off, it has been a struggle.

Please add to that document that members of the profession need to consult with patients to confirm accuracy of their records or current health situation. Doctors need to understand that the best team is the patient and doctor working together, because to be brutely blut, in Manitoba the system is completely broken.

My first comment, I appreciated the clarification highlighting the important burden of ensuring patient care (I am envious, this is a fantastic addition).

A large concern with reading that document is that it touches on the legal defense of doctors, but does not really touch enough on the importance of those records for the protection of patients and the

public body. Lets face it doctors make mistakes (these can be reduced, see below), and I caution the way this document may be perceived because it doesn't really go enough into the importance of records for the protection of the patient and public (I was very concerned the way it read). I for one am used to the burden of protecting persons/environment/property, and as an observation reading that document, I find it odd that the document reads more like it was from a medical insurance broker.

I'll use my unfortunate situation as an example. My records are messed up with many errors, I've have no choice but to spend rediculous amounts of time researching and keeping my body alive on my own because I can't get treatment or support due to the mishandling of my records (I sympathize for my family doctor that can't do anything for me because of the mess currently at HSC/St.B), the ego of some professionals has been disconcerning (waste of a visitation, no resolution), others appear to operate at a technician level. In my case I've tried repetively to correct or steer away from a situation totally and completely out of control, alas to no avail.

For the love of whatever you believe in please address the following:

- Add patient-doctor discussions to confirm accuracy of records and their current situation. Our health can shift, especially when for some broken reason we can't get treatment.
- Add patient-doctor collaboration, I want the medical knowledgebase to grow (as a body we have deceived ourselves, there is still much to learn and discover towards the diagnosis and treatment of people).
- Patients need easy access to their records to verify their content and accuracy.
    - Given the document eludes that the record belongs to the patient, it would be fantastic if we had secure access for periodic review without the need for these rediculous PHIA/FIPPA requests. I'm actually quite frustrated with this PHIA/FIPPA situation because as much as your document states the patient should be provided with access to their own records, it is not easy to gain access to their records, plus its expensive, and as a patient you can't get your records fast enough to stop/prevent a runaway train-wreck.
        - In todays day and age we have laboratory information systems (LIS) and other collaborative information systems, it wouldn't be difficult to have secure patient login.
    - Another benefit to transparency between the doctor and patient is that the barrier you are creating is eliminated. By eliminating barriers so that the patient needs can be addressed in an more accurate and pleasant fasion you're in turn reducing the amount of medical mistakes, and in turn the concerns about mal-practice and lawsuits. In general by maintaining a barrier all you're doing is contributing to errors, distrust (both ways), which adds to manitoba medical costs, and damages to your patients both in health and other losses.
- Add a section detering conflicts of interest, or the lack of medical thought or judgement.

Stakeholders

Thank you for the opportunity to respond to your Standard of Practice for Documentation in Patient Records and the Standard of Practice for Maintenance of Patient Records.

I have taken the opportunity to review both documents on behalf of the College of Physiotherapists of Manitoba.

I applaud you for the updated standards which recognizes the technological changes that now exist in the environment, and the longitudinal patient care that is prevalent today. Mitigating risks associated with abandoned records, an issue which our College also deals with, is also an important factor to address in your standard.

We have no further additions to suggest.

Email 1)
The following is the feedback from Manitoba Health and Seniors Care on the proposed Standard of Practice for Documentation in Patient Records:

- There appears to be a typo in section 2.5 – "the names [of] persons seen…"
- In the Preamble, it would be beneficial to reference that the requirements in the standard are in addition to both PHIA and the Personal Health Information Regulation made under the Act.
- Re: section 2.4, it would be beneficial to note that CPSM members must complete PHIA training, including regular refresher training. Shared Health and RHAs have their own training and the Department makes free training (including refresher training) available online: https://www.gov.mb.ca/health/phia/training.html (and produces certificates for people who complete the initial training and refresher training).

Email 2)
The following is the feedback from Manitoba Health and Seniors Care on the proposed Standard of Practice for Maintenance of Patient Records:

- In the Preamble, it would be beneficial to reference that requirements of PHIA and the Personal Health Information Regulation also apply to maintenance of patient records.
- Re: section 4.4 – it may be beneficial to reiterate the requirement in the Personal Health Information Regulation (the ``Regulation``) that security safeguards must be audited every two years (see section 8 of the Regulation)
- Re: Security and Storage Measures – The Standard should perhaps include reference to the specific requirements in s 18 of PHIA in terms of specific security safeguards and consideration should be given to including a reference to the requirements respecting orientation and training for employees and agents of the trustee respecting the trustee`s security policies and procedures per section 6 of the Regulation.

In addition, it would be beneficial to include a requirement for physicians, and their employees and agents to complete PHIA training, including regular refresher training (MHSC requires refresher training every 3 years). Shared Health and RHAs have their own training and the Department makes free training (including refresher training) available online: https://www.gov.mb.ca/health/phia/training.html (and produces certificates for people who complete the initial training and refresher training).

- Re: section 4.6.1 - The PHIA Pledge is not really an "agreement" so this may be confusing. This section should also perhaps reference that having trustee staff/agents sign the pledge is a requirement per section 7 of the Regulation.
- Re: section 4.10.1 - It is unclear what is meant by "privacy standards" as PHIA doesn't use this term. Is it meant to include the requirements of PHIA and the Regulation re: use, disclosure, retention, security and destruction of personal health information?
- Re: section 4.12.3 - It may be beneficial to note the requirements re: correcting records in clause 12(3)(a) of PHIA
- Re: section 4.17.3 and/or 4.24– It may be beneficial to reference clause 2(a) of the Regulation which relates to secure destruction

2.6.1 Not everyone has MHSC and PHIN. Could add "or other identifier, if available". What do they mean by gender identity? Different from administrative sex?

2.8.1 Unclear what is meant by "prepopulated"? Should better define "prepopulated template". Eg. on a lab form, name and demographic info is often prepopulated. Is that ok?

2.8.2 What is meant by "template" and "macro"? Could be more specific or remove the term "macro", as it may be specific to a certain EMR vendors.
Is 2.8.2 related to 2.8.1, or is this talking about something separate from prepopulated templates?

2.15 Define "late"?

3.1.2 Consider replacing "usual provider" with "main provider", since that is what is used in Home Clinic terminology by Manitoba Health and Shared Health.

3.3.4 What "plan" is this referring to? This is the first time a plan is mentioned in this section.

3.3.4 iv. What does "rationale for the prescription" refer to? What is "plan for management of same"?

3.4 What is EMR summary of care? Example? EMRs are a summary of care by nature. Is additional functionality required beyond what is in 3.5? EMRs already have areas in the EMR where you can access summary of care data. Is this referring to additional functionality? Can this be made more relevant to electronic record, or is this mainly aimed at paper charts?

Standard of Practice – Maintenance of Patient Records in All Settings

Is "in All Settings" necessary in the title?

Standard of Practice — Says eHealth and eHub. Should just say eHealth_hub services. May also want to consider listing these services (available here: https://sharedhealthmb.ca/services/digital-health/ehealth-hub/)

DPIN should not be in the list as it is not linked to EMRs.

Digital Health needs to be involved with this review in the future (before 2026). 3.7 What is meant by “maintenance agreement”? 4.7.1 Define “promptly”? 4.10 Could mention concept of certified EMR in Manitoba for primary care. 4.26 Is information management different from maintenance agreement? When are these two concepts the same and when are they different?
Both standards are very detailed and comprehensive; we found a number of the sections to be very helpful as common queries we receive on our similar standards (e.g., inpatient/emergency/institutional care, presumption of responsibility, timeliness of responding to requests for copies). CPSM may wish to consider the following for the *Documentation…* standard: 2.12 Should members ensure inclusion of communication with patients that may occur via social media? 2.16 Examples of when alterations are appropriate may be helpful, as well as clarification on whether alterations have to be initiated by a patient or if the member has an obligation to amend incorrect information. 2.16.1 It may be helpful to provide a definition or examples of what might constitute “misleading” information. 3.1.2 In determining expectations of ongoing care, would it be appropriate to discuss the matter with the patient to ensure they are clear on the professional relationship (particularly in situations where the physician may consider the care episodic in nature)? CPSM may wish to consider the following for the *Maintenance…* standard: 3.11.2 Where members relocating do not have custody/control of the patient records, how will associated costs be managed (e.g., if the member is choosing to relocate – not the patient – is it appropriate for the patient to be charged to have Their record transferred to the member’s new location, or should the member bear the cost)? This is a very common issue for us. 4.20 Does the patient record retention period include the record in its entirety (e.g., the record of a long-term patient has to

maintained in its entirety, even if it goes back over 30 years)? This is also a common question for us with a number of members assuming they only need to retain the last 10 years' worth of records.

4.20.2 Should records involving (allegations of) sexual/abuse of a minor patient be retained longer than indicated?

If you have any other questions or require additional information, please let me know how I may be of assistance.

HSC Health Information Services reviewed the standards and have some comments which are below.

What is the disciplinary process if members do not adhere to these standards? E.g. Institutional rules & Bylaws. What is the follow-up action and how do we go about enforcing it?

Documentation in Patient Records

2.6.1.
- What is the definition of 'gender identity'?
- Is it the gender on the Manitoba Health card, which is captured in ADT as per standards or is it the identity the individual identifies as?

2.10.
- What Abbreviations are approved?
- In 2.10.3 'understood in the member's area of practice' mean that members are allowed to use abbreviations in their own personal practice charts?

2.12.
- What defines Clinical Care? A two-minute phone call?
- Where in the chart should they be documented in an EPR? For example, if the member speaks to a patient about a test they need to take prior to their appointment, does the member document on the future visit or create a new visit?
- Are emails to be printed and kept in the chart? The entire email or just portions?

3.2.
- 3.2.4. Requisitions
    - Where should this be stored? Example, Diagnostic Requisitions get scanned into RIS, is this adequate knowing that not everyone may be able to view them?
- 3.2.9. Tasks & Communications
    - What is included in this?
- 3.2.10. Insurance and third-party related forms (e.g. WCB, MPI, disability, etc.)
    - Where should this be stored?

Maintenance of Patient Records in All Settings

Standard of Practice
- eHealth should be Digital Health

4.8
- for what situation? Is it inpatient? Clinic? How does the member decide what is necessary?

4.10
- Who are EMR Service Providers

4.20.
- Clarify that the 10-year retention period applies to community clinics not institutions.

I appreciate the opportunity to participate in this review and have a comment identified below in green.

2.6.1. Standard identifiers, including the patient's full name, date of birth, MHSC number, PHIN number and gender identity must be collected and documented. – is there a clinical need to capture the individual's sex, in addition to their gender identity? These are two very different concepts.

During this review, I identified a few questions and concerns about how these Standards would apply to the role of physicians who provide the Online Medical Support (OLMS) for field paramedics. Specifically:

3) The documentation Standards do not specifically reference a circumstance such as OLMS. Does this mean that we can rely upon the paramedics to document our advice and involvement as an OLMS physician? It will be logistically impossible for us to personally document a note in the EMS record of each and every patient province-wide with our current paper based system.

4) Similarly to 3), the document on the Maintenance of Patient Records does not really contemplate the circumstance of OLMS. As ERS physicians, we do not maintain any control over the security or storage of EMS patient record.

The above identified concerns are shared by the College of Paramedics of Manitoba. As such, I have included Trish Bergal, the Registrar of the College of Paramedics in this e-mail. I was hoping that Trish and I might be able to meet with yourself or other representatives from the CPSM to further clarify the role of the OLMS physician in the context of these new Practice Standards.

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

July 12, 2021

Via email: patientrecords@cpsm.mb.ca

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

Dear Dr. Ziomek:

Re: Consultation on CPSM's Draft Standard – Patient Records

Thank you for providing the Canadian Medical Protective Association (CMPA) the opportunity to participate in the consultations on the College's two draft Standards of Practice, Documentation in Patient Records and Maintenance of Patient Records.

As you know, the CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medico-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 100,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medico-legal issues.

The CMPA welcomes the College's initiative to update its Standards concerning medical records. The CMPA is pleased to offer the following comments on the two draft Standards. It also encourages the College to reference in both draft Standards that physicians can contact the CMPA if they have medico-legal questions concerning issues related to patient records.

Maintenance of Patient Records Standard

Reference to the Personal Health Information Act

Several sections of the draft Standard reiterate provisions from the *Personal Health Information Act* (*PHIA*) and its Regulation. It would be helpful if the College provided additional guidance and examples to assist physicians in understanding how these statutory obligations apply to their practice.

For example, paragraph 4.6.3 of the draft Standard provides that physicians responsible for maintaining patient records must ensure protocols are in place to regulate who can access patient

records, including controls to ensure that patient records cannot be used unless the identity of the person seeking to use the information is verified as a person authorized to do so, and the proposed use is verified as being authorized under the *PHIA*. While this is consistent with section 18(2) of *PHIA*, it would be helpful to provide examples of reasonably feasible measures that physicians may use in practice to meet these requirements.

Similarly, paragraph 4.9.1 of the draft Standard requires that trustees have a written policy that includes requirements for the security of personal health information when a record of the information is removed from a secure designated area. This is consistent with section 2 of the *Regulation*. However, it would be helpful to provide additional guidance to physicians on how this can be achieved. For example, such guidance might specify whether it is acceptable to store identifiable personal information on mobile devices and what safeguards should be in place to protect the information.

EMR linked to provincial systems

The College may want to address an inconsistency in the first paragraph under the heading "Standard of Practice" on page 2 of the draft Standard. The draft Standard indicates that while working with an EMR linked to provincial systems is not yet a requirement in this Standard, CPSM considers this arrangement the current standard of care and states it will likely become a requirement for all members when the Standard is reviewed again in or around 2026.

We are concerned that this language will create confusion as to what is currently required under the Standard. If the Standard will not currently require integration with provincial systems, it would be preferable if the draft Standard simply advised physicians that this requirement will likely be added when the Standard is next reviewed.

Conflicts Regarding Medical Records Custody

Paragraph 3.11.3 currently states that "In all situations, members must prevent conflict from compromising patient care related to difficulties imposed by one member or medical clinic on another related to accessing patient records." It would be preferable if this section instead required that: "members must take all reasonable steps within their control to prevent the conflict from compromising patient care."

We are concerned that this proposed requirement, as it currently reads, suggests that physicians might be responsible for the acts of others, regardless of whether in fact the physician has any control over the acts of those other individuals.

Other Applicable Authorities

The draft Standard acknowledges that it is not intended to comprehensively reference all enactments or rules applicable to patient records. However, it may be helpful to consider alerting physicians of other important privacy legislation that may apply to their medical record practices depending upon the context.

For example, physicians working for the Federal Government (including the Canadian Military) may be subject to the federal *Privacy Act*. The federal *Personal Information Protection and Electronic Documents Act* may also apply with respect to the requirement to notify the Privacy Commissioner of Canada and affected individuals of any privacy breach in a private clinic that

creates a real risk of significant harm to individuals. Currently, paragraphs 4.9.2 and 4.9.3 of the draft Standard address security breaches, but make no mention of mandatory reporting obligations. The College might also consider referring physicians to the Manitoba Ombudsman resources for responding to privacy breaches.

Documentation in Patient Records Standard

Completeness of records

Paragraph 2.12 of the draft Standard on Documentation in Patient Records provides that physicians must include in the patient record (e.g., through document scanning, file upload, or other means) details of all communication with patients related to clinical care provided by the member that occur via telephone, or other digital means (e.g., email, patient portals or other digital platforms), including the mode of communication. It would be helpful if the draft Standard specified that where it is not possible or practical to upload communications that occurred via digital means, a documented summary in the medical record regarding the essence of the communication would also be acceptable.

Informing patients about privacy rights

Paragraph 2.18 states that physicians must reasonably notify patients in their professional practice about their access and privacy rights, including the right to request a correction. We recommend clarifying that physicians are not required to expressly advise patients of all aspects of their access and privacy rights.

It would be preferable to encourage physicians, for example, to post the Health, Seniors and Active Living poster on the clinic's website and at their physical practice location, which provides patients with appropriate information and resources to obtain information about their access and privacy rights. We are concerned that without such a clarification, physicians may interpret the Standard as requiring an explicit discussion with patients regarding their rights of access and correction. Such discussions would place an undue burden on physicians.

Request not to share personal health information

The Health, Seniors and Active Living poster referenced in footnote 4 of the draft Standard indicates that patients can advise their health information trustees not to share their personal health information with a healthcare provider and the trustee will not share that information unless permitted or required to do so by law. It would be helpful if the draft Standard provided additional guidance to physicians on how to manage such requests.

For example, the College of Physicians and Surgeons of Ontario's Policy on Protecting Personal Health Information provides such directions to physicians. It requires that the physician engage in a discussion with the patient about the potential health risks and limitations of restricting access to personal health information to other healthcare providers, and requires that other providers be notified that additional relevant information in the file cannot be disclosed.

We hope these comments will be helpful to the College in finalizing the draft Standards on Maintenance of Patient Record and Documentations in Patient Records.

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer/Executive Director

LAC/ml

cc. Dr. M. Cohen

Doctors Manitoba
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R3X 0E8 Canada

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T: 1 888 322-4242 (toll free)
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July 16, 2021

VIA EMAIL

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

patientrecords@cpsm.mb.ca

Dear Dr. Ziomek:

Doctors Manitoba appreciates the opportunity to comment on the two proposed Standards – Documentation in Patient Records, and Maintenance of Patient Records.

We will address each proposed Standard in turn.

Generally, Doctors Manitoba submits that these proposed Standards are a creditable effort to modernize recordkeeping, including the move to electronic medical records by most members.

As we will highlight below, the proposed Standards do not address the growing problem of conflicts when physicians leave non-physician controlled clinics. The rules respecting the transfer of patient records remains unclear. This is an area we should work together to develop, to ensure continuity of patient care and protect patient safety.

Members will note that these Standards will impose additional obligations. Generally, these obligations do not appear to be unreasonable, but we encourage the CPSM to provide support and education to our members to ensure they are aware of their obligations. For many members still maintaining paper charts, the switch to electronic medical records will be challenging and stressful.

Our members also report greater expectations from patients respecting their ability to provide information to, and receive information from, physicians. Our office is receiving a growing number of calls and emails respecting medical charts. Doctors Manitoba encourages the CPSM to continue to update information for the general public.

Documentation in Patient Records

We have the following few specific concerns about the Standard on the Documentation in Patient Records:

- Section 2.6.2 mandates not only the collection of current contact information but also an emergency contact person. Concerns have been raised that emergency contact information is unlikely to be reviewed in a timely way, and out of date information may be worse than no information at all. It has been pointed out that PHIA prevents the discussion of health information with the contact person in any event. Emergency contact information is most

useful – and essential - at the time of admission to a hospital or facility, but far less for a community clinic. We would suggest this be a recommended practice, but not required.

- Section 2.14 requires charting to be in English only. We have not canvassed our membership to determine whether we have any members who still chart in French. Is this a new requirement? Has the CPSM determined whether there are any concerns in requiring charting in English to the exclusion of French, and consulted with Francophone organizations?
- Section 2.15 requires date and time stamping, which is of course accepted practice. However, the Standard should clarify what is “contemporaneous”: if a member dictates notes later in the day or the next day, is this a “late entry” which must be noted? The section should include some reasonable context and allow for entries to be prepared within a reasonable time without being noted as a “late entry”.
- Section 2.16 prevents the alteration of patient records, which is again accepted practice. This is clear for paper records but may create challenges for electronic records (as anyone who uses dictation software, particularly in technical fields, can appreciate). We suggest the section could allow for the correction of incorrectly transcribed words without the need to create a new entry (we understand that most, if not all, EMR systems will retain the details of the amendment).
- Section 3.5.8 requires the cumulative summary of care to include “immunizations”. A member will not know a new patient’s immunization history, and asking the question of the patient in the standard “meet and greet” is unlikely to assist. While this requirement is limited to information which is “available and relevant”, we think it would be clearer to state that only the immunization history while in the care of the physician (or clinic) should form part of the summary of care, unless the member obtains the information from the patient.

Maintenance of Patient Records

Our comments on the Standard on the Maintenance of Patient Records are as follows:

- We agree that EMRs are "the current standard of care” and note that physicians still using paper will be required shift to EMRs in the next five years. As we have stated above, this will be a challenge for some members, and we hope that the CPSM will provide suitable education and support to assist members in doing so. The requirement to maintain EMRs should not be seen as a reason for members to cease practice.
- We support the requirement that members practicing in private medical clinics (other than locum tenens) are "presumptively responsible" for the custody and control of patient records. This can be transferred to another trustee (the clinic) by agreement. There will now be a requirement for an agreement to set out these responsibilities, including who can access the records, and who has "ownership, control, and custodianship". Where no such agreement exists, it will have to be created within one year of the standard coming into force. We are aware that many members do not have a written agreement with their clinic, let alone an agreement which deals with the custody and control of patient records, and we hope that the CPSM can provide some direction and possibly templates for language that would be satisfactory. We would be prepared to work with the CPSM on this project as we anticipate questions from members.
- We note that the proposed standard does not address a fundamental and increasingly challenging question: what happens if there is a dispute respecting patient records at the end of a physician's tenure at a clinic? This is a challenge where the clinic is managed and

controlled by physicians where the CPSM can intervene; it is a potential nightmare where the clinic is owned by others. The CPSM cannot order a non-physician to comply; the CPSM may insist a member proceed to litigate under the contract instead. This leaves patient safety, and the continuity of patient care, at risk. This will not be solved by an amendment to the Standard at this time, but is an issue we would like to address in the near future. One possible solution would be to provide that only a physician can have control or custody of a patient's medical records, and the written agreement with the clinic would provide how the information can be accessed for the benefit of the patient. Only physician-owned clinics could specify other presumptions respecting medical records (for example, that the patient records remain with the clinic if the physician leaves). Another possible solution is to set out a limited number of outcomes (i.e. records presumed to stay with clinic, records presumed to go with physician, letter to each patient to make choice at the time, etc.).

- We note the increased responsibilities of Medical Directors of clinics, who are "deemed to share jointly with the medical clinic all maintenance responsibilities respecting the patient records that the clinic manages". There has been a steady increase in the obligations the CPSM has imposed on Medical Directors. In large part, this is helpful for members – particularly if Medical Directors have the authority to act and protect the interests of members and patients - but we are not satisfied that members appreciate what they are getting into should they take on the role. We encourage the CPSM to provide materials and education for members (and clinic owners) on the duties and obligation of Medical Directors.

Thank you for the opportunity to comment on these proposed Standards.

Sincerely,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

Archived: November 23, 2021 10:21:10 AM
From: Rachael Porter
Sent: Mon, 19 Jul 2021 14:50:20 +0000ARC
To: Patient Records
Subject: Public Consultation on Standard of Practice for Patient Records
Importance: High

As I was on holiday I was unable to provide feedback on Friday. Please accept my feedback, thanks.

1.2. **"EMR"** means an electronic medical record or electronic patient record and includes any computer-based patient record that is created digitally or stored digitally (e.g., a patient record that has been scanned).

Feedback: Suggest using the term **Digital Record** versus EMR as an EMR reflects one specific type of system usually used the community setting.

1.5. **"Outpatient"** means a patient who is not admitted as an inpatient at an institutional setting. This includes patients attending an emergency department who are not admitted and patients who have been discharged from an institutional setting.

Feedback: Suggest simplifying this definition as it is confusing and call it what it is Emergency patient (which includes urgent care).

1.6. **"Non-Emergency Department Outpatient"** means the same as paragraph 1.5, above, but excludes patients being cared for in an institutional emergency department or institutional urgent care department who are not admitted.

Feedback: Suggest simplifying this definition as it is confusing, suggest calling this definition outpatient.

2.6. Members must ensure that both patient identification and reliable contact information are captured in the patient record.
- 2.6.1. Standard identifiers, including the patient's full name, date of birth, MHSC number, PHIN number and gender identity must be collected and documented.
  - i. If not available, the reason must be documented.

Feedback: MHSC is no longer a term it is called MH#. When you are referencing Gender Identity are you speaking about how the patient identifies or their sex at birth. This is a growing concern so please be clearer and if you are wanting Gender Idenity you also need to include sex.

2.9. Members must not copy and paste an entry related to a prior encounter with a patient unless the copied entry is modified to remove outdated information and include current information which reflects the actual circumstances the encounter entry is meant to reflect.

Feedback: Not sure how a member uses the computer system is really relavant as each system offers different technology i.e. copy forward, copy to. What really are you wanting the physician to do "write accurate notes" how they do this should be up to their professional judgement.

2.10. Members must avoid the use of abbreviations that are:
- 2.10.1. peculiar to only the person creating the entry such as to be confusing or unknown to other readers,
- 2.10.2. known to have more than one meaning in a clinical setting, or
- 2.10.3. that are otherwise not commonly used or understood in the member's area of practice.

Feedback: Suggest you say the use of abbreviations is discouraged. Most of our policies discourage the use of abbreviations. If you are in a specific program (obstetrics) something very common to that program is used and other programs do not know what it is being a shared chart this is a patient safety issue. So suggest this is ammended.

Communication with patient

2.12. Members must include in the patient record (e.g., through document scanning, file upload, or other means) details of all communication with patients related to clinical care provided by the member that occur via telephone, or other digital means (e.g., e-mail, patient portals or other digital platforms), including the mode of communication.

Feedback: This contradicts our shared health policy as we do not file email communication in the chart as the documentation is usually unprofessional and not in the manner as medical information is collected.

2.17. Where alterations are made, members must consider whether to notify any health care providers involved in the patient's care, particularly when the correction would have an impact on treatment decisions.

Feedback: Under the personal health information act you must inform others of the correction it is not a consideration.

3.2.4. Requisitions (e.g., labs, diagnostics)

Feedback: We do not retain requistions in the chart.

4.3. The member responsible for the care of an inpatient must complete an appropriately complete discharge summary in a timely manner consistent with the requirements of the institution.

Feedback: Please add that the member is responsible for tracking this information.

4.27.1. notify patients, or their representatives, about where patient records are to be located, and

4.27.2. how the records can be transferred to another member or how copies can be obtained.

This is not required if the member's patient records are maintained by *"a person or organization that employed, engaged or granted privileges to the member and is a trustee under The Personal Health Information Act"*.

Feedback: Notation must be included in this section outlining that if a provider CHOOSES to maintain an **additional** separate private (still must use institutationalchart) patient chart outside of the institutional chart they become responsible for this patient chart and must follow all the standards related to the chart like a private clinic.

Rachael Porter
Director, Health Information Services
Shared Health
HSC Privacy Officer
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Planned Absence: July 1, 2021 – July 18, 2021

Manitoba Society of Physician Assistants

Registrar

Standard of Practice Feedback

CPSM

1661 Portage Ave | # 1000 | Wpg, MB | R3J 3T7

Greetings,

July 16, 2021

On June 10th, 2021, the College of Physicians & Surgeons of Manitoba (CPSM) put out a call to its members, stakeholders, and the public to review and provide comments on three proposed Standards of Practice (SoP): (1) Virtual Medicine (2) Documentation in Patient Records and Maintenance of Patient Records and (3) Performing Office-Based Procedures
The Manitoba Society of Physician Assistants (MSoPA), in collaboration with the Canadian Association of Physician Assistants distributed a survey with the following stem to answer the call and provide the CPSM with a collective voice from PAs and CL.A in Manitoba:

"The role of College of Physicians and Surgeons of Manitoba (CPSM) is protection of the public through self-regulation. CPSM recently provided updates to their Standard of Practice (SoP) documents regarding virtual medicine, record keeping, and procedures. The purpose of this survey is to collect responses from Manitoba physician assistants (PAs) to provide feedback to the CPSM. Our responses should be focused on helping CPSM achieve their goal using the perspective of the Manitoba PA."

The following is a list of responses we hope you find helpful to assist in your revisions of these crucial Standard of Practice documents.

38 Devonport Blvd | Wpg, MB | R3P 0A9|Email: info@msofpa.ca | Phone: 204. 230. 1992

Regarding SoP Virtual Medicine: 4.2.1.ii

1) The document indicates Physicians - PAs provide virtual care. With Ontario and Alberta Regulating PAs, I could see a corporation using PAs under a Physicians "supervision" providing contracted services according to provincial guidelines in the future. Should the wording be more specific and indicate authorized members i.e MD/PA/Cl.A.?
2) If a MB resident living outside of MB contributes to MB economy/tax then it should be fair that we care for them wherever they live.
3) This article does require some clarity. For patients who have cabins a few hours away in Ontario, must they travel over the border in order to have a virtual appointment with their provider in Manitoba? Does the document need to state that location was confirmed for each virtual visit?
4) Manitoba PAs are currently providing virtual care to patients who live outside of Manitoba close to the border. They have provided virtual care to patient's temporarily visiting other provinces so the Standard of Practice would change current practices.
5) This article does create some confusion as it does not specifically mention Manitoba residents needing medical assessment while abroad. Either provincially or internationally. Additionally, this article does not address residents from other provinces that routinely access health are in Manitoba. Can these 2 points be clarified to avoid the unintentional repercussion of limiting access to medical care and the negative impact that could have on the public?
6) What would the definition of “appropriate steps” be specifically? Should it read “reasonable steps” instead?

Regarding SoP Virtual Medicine: 5.1.1.i

1) In-person assessment should be determined in an appropriate and timely manner
2) The care provider should explain the reasoning of in-house exam to the best of their abilities. If the patient refuses to come in then the provider should advise the patient of the possible risks of not being assessed in person. The provider

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should document that reasonable effort was attempted to further investigate the possible clinical problem

3) Patients been using virtual care for convenience or perceived risk surrounding the pandemic, both of which might be considered inappropriate for virtual care, but often the request to be seen in person is refused
4) This article would be necessary to ensure that providers in the community do not refuse in-person visits or conduct in-person visits when it is not in the best interests of the patient and the public. This article does not provide direction or establish the standard for a situation where the patient is not able or agreeable to be seen in person. Perhaps this should be addressed because many patients are elderly with limited mobility or have financial or social issues that keep them from coming to in-person visits. The concern would be potential for patients being sent to the urgent care or ER for in-person assessment which can lead to unnecessary harm and burden on the already stressed system.
5) Should it be written in a language that implies the onus is on the clinician to schedule an in-person assessment vs advising the patient and providing guidance for them but not necessarily arrangement on their behalf? If the patient fails to attend, is the clinician responsible for outcomes?

Regarding SoP Virtual Medicine: 5.3.3

1) Does confidential storage mean recording the appointment?
2) Can the CPSM review and approve a virtual health care platform to secure the medical content?

To provide CPSM with additional insight into the Manitoba PAs role in Virtual Medicine, we asked our members to comment on the following question:

"Does CPSM SoP Virtual Medicine and Contract of Supervision accurately address the physician/PA relationship within a virtual medicine content? (ie: Do both physician/PA need to be onsite for virtual care?) Please expand on your thoughts and how this applies to your practice."

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1. No it does not. However, PA delivered Virtual Care is possible with telecommunication similar to remote practice. However, I believe the Contract of Supervision and Practice Description require authorization for Virtual Medicine to be inserted for this authorized practice
2. PAs should act as an extension of the Physician and its physical location should not be a factor. I feel that we can provide virtual medicine care with physical distance between PA and his/her supervising physician.
3. In general, we treat virtual care the same as in person care; that the supervising physician needs to be accessible as required
4. I have access to EMR from home. There are days when all clinic appointments are virtual. On these days, I call the patient and conference call the supervising physician for review. However, my Contract of Supervision stipulates that both physician/PA must be onsite. In my clinic, our dietitian and social worker are working from home by making their phone number private to call patients for their appointments.
5. The templates for the institutional and non-institutional Physician Assistant Practice Descriptions that were recently used across Manitoba do not contain sufficient inclusion of Virtual Medicine. The Virtual Medicine SoP does not directly address the common and complex relationship that exists between a Physician Assistant, their Physician supervisors, and Society. Because of this, access to medical care could be negatively affected because the SoP could limit the Physician/PA team to in-person visits through failure to include/mention. I am not involved in Virtual Medicine, but I am concerned that there could be an unintended negative social impact through unnecessary restriction of access to PAs through Virtual Medicine.
6. I would like clarification on this; virtual billing fees are already reduced; what's the incentive for an MD to use a PA if they must be present for the virtual visit? My MDs aren't present in the exam room when I'm seeing patients, what's the difference if we review after?
7. I don't think the SoP needs to be onsite specifically because someone is being seen virtual.

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Regarding SoP Office Based Procedures 4.1 & 4.2

1) PA/Cl.A are members of CPSM. I read this section as indicating Associate members as being able to supervise non-members in some procedures.
2) I feel that this paragraph does not identify the PA as the primary and my personal interpretation is that it can be anyone delegated by the physician and the physician should personally examine the patient receiving the invasive procedure.
3) I feel this article will place an unnecessary burden on one clinician rather than allowing individuals to assess their own skills.
4) "Delegate" is not included in the standards definitions. There needs to be a clear definition for delegate or perhaps "delegate member".
5) I would prefer to see Associate Members or Physician & Clinical Assistants specifically mentioned. Additionally, the term delegate implies that the task or procedure has been delegated which specifically excludes PAs/CAs and nurses as Physicians cannot legally delegate to other CPSM Regulated Health professionals as per the RHPA
6) This is a slippery slope; if we only allow those with most experience to be the ones performing the task, how will anyone develop?
7) Does this mean I can't do a simple excision without the patient being personally assessed by a doctor? that seems unreasonable.

Regarding SoP Office Based Procedures 4.4

1) I believe it is clear.
2) It does not have a clear identifying factor for the non-physician provider. But it does not affect my practice for my current set up.
3) I think it equates "member" with physician and ignores PAs and our ability to delegate if needed.
4) The definition of member is "a member or associate member of CPSM". Therefore, interpretation of this SoP from PA perspective tells me that PAs can delegate office procedures to a medical or PA student for example. I think this is clear.

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5) This article is restricting non-CPSM members. I foresee concern about who which non-CPSM members this applies to since the CRNM has concluded their members can not receive delegation from Physicians. The RHPA restricts delegation to outside their membership which includes PAs and CLAs which seems appropriate as they are supervised and not delegated to.
6) What constitutes "supervision"? Is it direct or indirect? If direct, then I may as well not be adding much value to my MDs practice

Regarding SoP Documentation and Maintenance of Patient Records Office 2.8, 2.81, 2.82

1) I believe it is clear
2) Some of my practice uses templates and I personally edit the entire template to reflect the pertinent patient care info. To me, this clause is put there to provide protection for college and not for the members.
3) We use templates and edit them based on the findings.
4) This will not change my practice even though I use templates with every encounter. The templates are set up so that I highlight and click specific phrases/sentences that were applicable to the encounter especially in regards to physical examination. There are templates I use that I do not modify often because it is repetitive information (ex. Information on COVID19 vaccine)
5) As a PA in an institutional setting, the use of MACROS is optional. As far as I know PAs in Manitoba institutional settings are not being asked to use macros by their supervisors.

Regarding SoP Documentation and Maintenance of Patient Records Office 3.5-3.5.8

1) Chief Concerns which may be different from a Problem List should be added.
2) I work in the inpatient setting. Rare outpatient setting work does not require such detail with every entry but when we do require, we put in more info than listed above.
3) We often have incomplete records, especially when a patient is under the care of a specialist. Medications and changes are the most common item that I find is incomplete.

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4) There are sections for all of the above in Accuro EMR. Pertinent things like medications get updated regularly. Allergies and drug reactions rarely get asked about in outpatient setting for updates.
5) This seems quite comprehensive. Some practices may have additional requirements but suggesting that this is the minimum requirement to ensure protection of the public is appropriate.
6) It is our duty to do complete hx on every patient even if they are there for a minor simple complaint

To provide CPSM with additional insight into the Manitoba PAs role in Virtual Medicine, we asked our members to comment on the following question:

"Is there any other feedback you have for the CPSM regarding these three SoP updates?"

1) Thank you for this opportunity
2) I am happy that CPSM is updating the SoP and I would love this format of review more often. Thank you.
3) Physician Assistants play a vital role in the Manitoba healthcare system. They have a significant impact on the health and wellness of our society and improve access to medical care in institutional and non-institutional settings throughout Manitoba. CPSM should consider specifically mentioning these associate members, whenever possible, in the standards of practice to help define how the PA/MD relationship should be evolving to protect the public as further implementation of these interdisciplinary teams continues.

Sincerely,

Your Manitoba Society of Physician Assistants Team

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Standard of Practice

Documentation in Patient Records

Initial Approval: **Effective Date:**

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

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

PREAMBLE

This Standard sets out the requirements of members for documentation of medical care. It is separated into four parts:

1. Definitions
2. General requirements for all practice settings
3. Requirements specific to non-emergency department outpatient care
4. Requirements specific to inpatient care and emergency department care

The requirements in this Standard are in addition to those required in sections 5, 10 and 11 of the College of Physicians and Surgeons of Manitoba Standards of Practice Regulation **("Standards Regulation")**, *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA"),** and regulations made under PHIA. Unless otherwise stated, the requirements of this Standard are to be read in conjunction with other documentation requirements for certain clinical situations that are set out in other CPSM Standards of Practice of Medicine. ~~Maintenance requirements for patient records and the record of appointments members must keep are dealt with in CPSM's Standard for Maintenance of Patient Records.~~

Note: Maintenance requirements for patient records and the record of appointments are dealt with in CPSM's **Standard for Maintenance of Patient Records**.

STANDARD OF PRACTICE

1. DEFINITIONS

For the purposes of this Standard:

1.1. **"Patient record"** means a record containing the information described at section 11 of the **Standards Regulation**. Section 11 of the **Standards Regulation** provides:

11(1) A member must appropriately document the provision of patient care in a record specific to each patient.

11(2) A member must document on the patient record the medical care given to the patient containing enough information for another member to be sufficiently informed of the care provided.

1.2. **"EMR"** means an electronic medical record or electronic patient record and includes any computer-based patient record that is created digitally or stored digitally (e.g., a patient record that has been scanned).[1]

1.3. **"Inpatient"** means a patient to whom a member provides care while the patient is admitted in an institutional setting (e.g., hospital).

1.4. **"Institutional setting"** has the same meaning as it does elsewhere in the CPSM's Standards of Practice of Medicine, which is:

(a) a facility that is designated as a hospital under The Health Services Insurance Act; or

(b) a hospital or health care facility operated by the government, the government of Canada, a municipal government, a regional health authority or CancerCare Manitoba.

1.5. **"Outpatient"** means a patient who is not admitted as an inpatient at an institutional setting. This includes patients attending an emergency department who are not admitted and patients who have been discharged from an institutional setting.

1.6. **"Non-Emergency Department Outpatient"** means the same as paragraph 1.5, above, but excludes patients being cared for in an ~~institutional~~ emergency department or institutional urgent care department who are not admitted as an in-patient.

2. GENERAL REQUIREMENTS FOR ALL SETTINGS

Part 2 of this Standard sets out requirements for documentation in patient records that apply to all members who provide care during one or more encounters to either inpatients or outpatients regardless of the practice setting in which the care was provided, whether care is provided in person or virtually or whether the documentation is paper based or digitally stored.

Overarching principles for documentation

[1] **Note:** For the purposes of this Standard, this definition will capture what are commonly referred to, colloquially, as EMRs, EPRs, EHRs, and digital records.

2.1. Documentation is an essential component of safe and competent medical care. Sections 5 and 11 of the **Standards Regulation** establish that members:

> *Must appropriately document the provision of patient care in a record specific to each patient*.

And:

> *When a member and one or more other health care providers are involved in the health care of a patient, the member must … document, on the patient record, the member's contribution to the patient's care.*

2.2. To meet this Standard and satisfy the requirements of the **Standards Regulation**, care must be documented in the patient record in a manner that facilitates:

2.2.1. maintenance of the expected standard of care over time,

2.2.2. other members or health care professionals acting on significant information in the patient record as and when required, and

2.2.3. a meaningful review or audit of the care provided by others, including by CPSM and other authorized health authorities when required.

2.3. For each encounter, documentation should be adequate for another member to take over care of the patient if needed.

Institutional rules and bylaws

~~2.3.~~2.4. Members who provide either outpatient or inpatient care in an institutional setting must comply with all legislation, by-laws and rules established by the institution. For members who provide care in an institutional setting:

~~2.3.1.~~2.4.1. where this Standard imposes requirements more onerous than those of the institution, then the more onerous requirements in this Standard must be followed, and

~~2.3.2.~~2.4.2. where this Standard imposes requirements less onerous than those of the institution, then the more onerous institutional requirements must be followed.

PHIA

~~2.4.~~2.5. It is a professional obligation that members be aware of, keep current with, and comply with PHIA's requirements for the collection, use and disclosure of personal health information.[2]

[2] Manitoba Health, Seniors and Active Living provides useful and comprehensive information and resources, including educational and training materials and templates, on its website: https://www.gov.mb.ca/health/phia/

Record of Appointments for Non-Emergency Department Outpatient care

~~2.5.~~2.6. While not part of an individual patient's patient record, members must create and maintain a record of appointments for their practice in accordance with section 10 of the **Standards Regulation**, which states:[3]

> *A member must keep a record of [their] appointments with patients and those persons seeking medical care indicating, for each day, the names of persons seen and patients for whom medical care was provided.*

Patient identification and contact information

~~2.6.~~2.7. Members must ensure that both patient identification and reliable contact information are captured in the patient record~~.~~:

~~2.6.1.~~2.7.1. Standard identifiers, including the patient's full name, date of birth, ~~MHSC number~~MH#[4], PHIN number, and administrative sex designation or gender ~~identity~~(i.e., the one that matches MH#) must be collected and documented.

i. If not available, the reason must be documented.

~~2.6.2.~~2.7.2. Standard contact information, including the patient's name, telephone number, address, ~~and an emergency contact person~~ must be collected and documented.

i. If not available, the reason must be documented.

ii. Secondary options for contact information may include an email address or contact information of an agreed upon intermediary.

2.7.3. An emergency contact person should be documented and kept current.

Accuracy and completeness

~~2.7.~~2.8. Members must maintain accurate, up~~-~~to~~-~~date, and complete patient records. This requires that they:

~~2.7.1.~~2.8.1. create entries contemporaneous with any care provided to a patient or as soon as reasonably possible thereafter, and

2.8.2. clearly indicate sources of information when it is not provided directly by the patient to the member or is not otherwise obvious by virtue of the nature of the information~~, and~~.

~~2.8.~~2.9. In creating an entry, the use of templates or macros carries substantial risk that information not relevant to the specific patient's actual clinical circumstance or the specific encounter may inadvertently be included in the patient record, rendering the entry unreliable or inaccurate. For this reason:

[3] **Note:** For clarity, this includes keeping a record of virtual visits.

[4] **Note:** It is acknowledged that not every patient will have an MH# (i.e., Manitoba Health #).

~~2.8.1.~~2.9.1. ~~Prepopulated templates~~ Templates or macros prepopulated with clinical information should be avoided.

~~2.8.2.~~ Members who use templates ~~and~~or macros must ~~thoroughly~~ review them and ensure that~~:~~

~~2.8.3.~~2.9.2. the content accurately and comprehensively reflects the care given~~, and~~.

~~i. the encounter is captured in a comprehensive way that does not contain inaccurate information or information not obtained during the encounter.~~

~~2.9.~~2.10. Members must not copy and paste an entry related to a prior ~~encounter~~visit with a patient unless the copied entry is modified to remove outdated information and include current information which reflects the actual circumstances the ~~encounter~~visit entry is meant to reflect.

~~2.10.~~2.11. Members must avoid the use of abbreviations that are:

~~2.10.1.~~2.11.1. peculiar to only the person creating the entry such as to be confusing or unknown to other readers,

~~2.10.2.~~2.11.2. known to have more than one meaning in a clinical setting, or

~~2.10.3.~~2.11.3. that are otherwise not commonly used or understood in the member's area of practice.

~~2.11.~~2.12. Members must take care to ensure that any documentation made in the patient record used for the purpose of remuneration faithfully represents the care provided. Diagnoses entered for the purpose of remuneration are used for public health surveillance, policy decisions and research, thus this Standard mandates that care should be taken to ensure all patient record entries accurately reflect the care provided during an encounter.

Communication with patient

~~2.12.~~2.13. Members must include in the patient record (e.g., through document scanning, file upload, or other means such as a written description) details of all communication with patients related to ~~clinical~~ care provided by the member that occur via telephone, or other digital means (e.g., e-mail, patient portals or other digital platforms), including the mode of communication. Members are exempt from this requirement when the following factors are met:

2.13.1. the communication is brief, unscheduled and outside a typical member-patient encounter,

2.13.2. the patient record is not readily accessible, and

2.13.3. the member, using good clinical judgment, determines documentation of the communication is not necessary respecting ongoing care.[5]

Organization and intelligibility

~~2.13.~~2.14. Documentation in the medical record must be understandable, legible, and organized in an appropriate chronological and systematic manner.

~~2.14.~~2.15. Documentation in patient records must be in English.[6]

Date and time of entries

~~2.15.~~2.16. Members must ensure that each entry in a patient record is dated and, when appropriate, timed. Members need not personally enter the date or time when that is already done by a digital system. If an entry is not made contemporaneous with the medical care given (i.e., the entry is made significantly later), then the member must clearly indicate as part of the entry:

~~2.15.1.~~2.16.1. the date and time for both the patient encounter and for the entry, and

~~2.15.2.~~2.16.2. indication that the entry is a late entry.

Alterations and Corrections

Alteration

~~2.16.~~2.17. Original entries in patient records must not be altered after the entry is made.

~~2.16.1.~~2.17.1. Where it is necessary to correct inaccurate, incomplete, or otherwise misleading information in the patient record, the member must date and sign off on the additions or modifications and either:

i. maintain the incorrect information in the patient record, which may be automatically done digitally, clearly label the information as incorrect, and ensure the information remains legible (e.g., by striking through incorrect information with a single line), or

ii. remove and store the incorrect information separately and ensure there is a notation in the patient record that allows for the incorrect information to be traced and readily accessible during the retention period of the patient record.

[5] **Note:** Even if an exemption applies, it may be considered prudent for medico-legal reasons for a member to complete their own documentation, concerning which the member would be required to ensure is maintained in accordance with PHIA and the Maintenance of Patient Records Standard.

[6] **Note:** This does not prohibit members from recording comments from the patient made in another language, though a translation must be provided when this occurs.

~~2.17. Where alterations are made, members must consider whether to notify any health care providers involved in the patient's care, particularly when the correction would have an impact on treatment decisions.~~

2.17.2. As an exception to 2.16.1., members may correct incorrectly transcribed words while finalizing a dictation without the need to create a new entry.

Corrections at patient's request

2.18. Members are expected to take reasonable measures to notify patients in their professional practice about their access and privacy rights and about their right to request a correction to the personal health information contained in their patient record.[7] Members must comply with section 12 of PHIA[8, 9] respecting the patient's right to request a correction in a patient record. ~~This includes that members must reasonably notify patients in their professional practice about their access and privacy rights, including the right to request a correction.[10]~~

Notice of alternation or correction to other health care providers

2.19. In all cases where alterations or corrections are made, members must consider whether to notify any health care providers involved in the patient's care, particularly when the alternation or correction would have an impact on treatment decisions. Respecting corrections, specifically at the patient's request, subsection 12(5) of PHIA requires that:

> *When a trustee makes a correction or adds a statement of disagreement under this section, the trustee shall, when practicable, notify any other trustee or person to whom the personal health information has been disclosed during the year before the correction was requested about the correction or statement of disagreement. A trustee who receives such a notice shall make the correction or add the statement of disagreement to any record of that personal health information that the trustee maintains.*

Documentation of care provided by member via another health care professional

[7] **Note:** This can be done by way of a poster or brochure. See section 9.1 of PHIA. Manitoba Health, Seniors and Active Living has created a poster which will adequately meet this requirement when posted on a medical clinic's website and at its physical location. The poster is available at: https://www.gov.mb.ca/health/phia/docs/access_privacy_rights.pdf

[8] See *The Personal Health Information Act*, CCSM c. P33.5, at subsections 12(1) – 12(6)

[9] Helpful information about what is required when a patient requests a correction is contained in the 'PHIA Policy and Procedure Requirements' document published on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

~~[10] Health, Seniors and Active Living has created a poster which will adequately meet this requirement when posted on a medical clinic's website and at its physical location. The poster is available on their website: https://www.gov.mb.ca/health/phia/docs/access_privacy_rights.pdf~~

2.20. Medical advice concerning the care of a patient that is communicated to another health care professional (i.e., another member or other health care professional such as a nurse or EMT), in-person or virtually, is considered care in respect to the patient and must be documented in accordance with this Standard (e.g., a consult while on call), even where providing the advice does not involve direct physical contact with the patient at the time it is provided (i.e., close physical proximity). Notwithstanding, members are exempt from this requirement in the following circumstances: [11]

2.20.1. The health care professional receiving the advice is being supervised by the member or acting under their delegation, including respecting documentation of care, and the member is already considered responsible for the documentation of that health care professional.

2.20.2. The member is practicing in an institutional setting, including on-call service for a department or emergency medical services, and communicates medical advice, in-person or virtually, to another health care professional (e.g., a consultation) respecting the care of a patient who the member is not in direct physical contact with at the time the advice is being given. In this situation, the member must follow applicable institutional rules and bylaws for documentation of the discussion and the medical advice given.

2.20.3. The member is practicing in a non-institutional setting (e.g., group call for a private clinic) and communicates medical advice concerning the care of a patient to another health care professional (e.g., a consultation), in-person or virtually, and following factors are met in the clinical circumstance:

i. the member is not in direct physical contact with the patient,

ii. the member providing the advice does not have immediate or reasonable access to the relevant patient record being created by the health care professional providing direct patient care,

iii. there is no reasonable expectation by the health care professional seeking the advice that the member providing the advice will document the conversation, and

iv. the member can reasonably satisfy themselves that the health care professional seeking the advice is documenting the conversation, including information provided, issues raised, and advice given.

2.20.4. For clarity, whenever documentation of medical advice is required (i.e., no exemption applies under this section):

i. the patient record must be maintained in compliance with PHIA and CPSM's Maintenance of Patient Records Standard, and

[11] **Note:** Even if an exemption applies, it may be considered prudent for billing or medico-legal reasons for a member to complete their own documentation, concerning which the member would be required to ensure is maintained in accordance with PHIA and the Maintenance of Patient Records Standard.

ii. best efforts must be made to ensure a copy of the record created forms part of the main patient record created by the person or persons providing direct patient care.

3. REQUIREMENTS SPECIFIC TO NON-EMERGENCY DEPARTMENT OUTPATIENT CARE

Part 3 of this Standard sets out requirements for patient records for all Non-Emergency Department Outpatient care, which is most often provided in a medical clinic setting. For greater certainty, use of the term outpatient in this part (i.e., Part 3) includes care provided in an outpatient clinic within an institutional setting. Specific requirements for emergency care in an institutional emergency department or urgent care department are dealt with at Part 4 of this Standard along with documentation requirements for inpatient care.

Documentation of expectation of ongoing care

3.1. Appropriately documenting the provision of outpatient care will often depend on the nature of the professional relationship that the member has with the patient and the care the patient reasonably expects from the member, including expectations for longitudinal care. In this respect, members must:

3.1.1. ascertain the nature of the relationship, including whether there is a reasonable expectation they will continue to see the patient, and

3.1.2. ensure the patient record reflects whether the member or the member's clinic[12] are considered the patient's usual primary care provider, or, if not, if the patient has a primary care provider and the name of that provider.[13]

Components of a complete patient record

3.2. For non-emergency department outpatient medical care, the patient record should contain the following components as applicable:

3.2.1. Cumulative summary of care when required (see below at paragraph 3.4)
3.2.2. Encounter notes, for consultants this may be the consultant's report(s)
3.2.3. Referral letters and consultant reports
3.2.4. Copy of requisitions (e.g., labs, diagnostics)
3.2.5. Lab and imaging reports
3.2.6. Pathology reports
3.2.7. Hospital (e.g., inpatient admission) and discharge summaries, including ER reports

[12] **Note:** When a patient attends repeatedly and consistently at the same medical clinic, then they are ~~assumed~~presumed to be receiving their primary health care from that clinic. The members ~~and medical director are~~at the clinic who have seen the patient become collectively responsible for offering ~~these patients~~the patient longitudinal medical care, subject to CPSM's **Practice Management Standard**.

[13] See CPSM's **Good Care Standard** respecting required communication with the patient.

3.2.8. Surgical and procedural reports
3.2.9. ~~Tasks and~~Intraoffice communications relevant to patient care
3.2.10. Insurance and third-party related forms (e.g., WCB, MPI, disability, etc.)
3.2.11. Other reports or documents as appropriate

Encounter note principles

3.3. All members must document, or already have in the patient record, the following for all outpatient encounters, including respecting acute or episodic care:

3.3.1. In the encounter is not in-person, the mode of communication (e.g., telephone).

~~3.3.1.~~3.3.2. A focused subjective history, including as indicated:
i. a history of the presenting complaint,
ii. appropriate social history and risk factors,
iii. pertinent family medical history,
iv. allergies,
v. active problem list,
vi. active medications,
vii. an appropriate review of systems, and
viii. any other areas as appropriate in the clinical circumstance.

~~3.3.2.~~3.3.3. Relevant objective examination, including adequate positive and negative findings from focused physical examination.

~~3.3.3.~~3.3.4. An appropriate assessment, including notation of tentative, differential, working or established diagnosis or diagnoses.

~~3.3.4.~~3.3.5. Adequate information about the plan, including the following as applicable:
i. all tests or investigations requisitioned, including a copy of the requisition, and any associated reports and results (e.g., laboratory, diagnostic, pathology),
ii. adequate information about referrals to and consultation and collaboration with other health care providers,
iii. adequate information about the management plan for the patient such that it can be understood by another member, including respecting actions taken based on examination(s) or investigation(s) and plans for follow up,
iv. any prescriptions issued, rationale for the prescription and plan for management of same, and
v. adequate information about any treatment or therapy provided, including procedural records, and the patient's response and outcomes.

~~3.3.5.~~3.3.6. Any treatments, investigations, or referrals that have been declined or deferred and the reason, if any, given by the patient, and discussion of the risks.

~~3.3.6.~~3.3.7. Significant discussions with the patient pertinent to their care, including advice given to the patient respecting any of the above.

~~3.3.7.~~3.3.8. Any other areas as appropriate in the clinical circumstance.

Cumulative summary of care

3.4. Members should always maintain an up-to-date cumulative summary of care when doing so reasonably contributes to quality medical care (e.g., summary cover sheet or section in written chart, or EMR summary of care). A cumulative summary of care is required as part of the patient record if one or more of the following apply:

3.4.1. the member is the patient's usual primary care provider,

3.4.2. the patient has attended the member repeatedly and consistently, irrespective of whether one or more of the individual encounters may be considered acute or episodic, or

3.4.3. the patient has repeatedly and consistently attended the ~~health care facility~~practice setting (e.g., medical clinic) where the member practices for outpatient medical care either from the member or another member with whom the member practices in association (e.g., a group medical practice). In this context, ~~the facility's medical director and~~ all members at the ~~facility~~practice setting who see the patient are collectively responsible for populating the cumulative summary of care over time.

3.5. A cumulative summary of care must include the following when the information is available and relevant (i.e., components required will be what is appropriate to the care needs of the patient and dependent upon the member's professional practice):

3.5.1. Past medical history

3.5.2. Problem List (e.g., ongoing health conditions, chronic disease, diagnoses)

3.5.3. Surgical history

3.5.4. Medications

3.5.5. Allergies and significant or worrisome drug reactions

3.5.6. Social history, including risk factors that impact health status

3.5.7. Family history

~~3.5.8. Immunizations~~

4. REQUIREMENTS SPECIFIC TO INPATIENT AND EMERGENCY CARE

Part 4 of this Standard sets out the requirements for institutional associated inpatient care provided by a member and extends to care provided in an emergency department or urgent care department setting regardless of whether the patient is formally admitted as an inpatient at the institution. It is emphasized the requirements in Part 2, above, apply to these settings.

4.1. Members must recognize that record keeping in an institutional setting is usually multidisciplinary and team-based and must document care accordingly.

4.2. Members must always be aware of their role and responsibilities respecting the continuing care of their patients and document any transfer of responsibility for

continuity of care, including in compliance with CPSM's Collaborative Care Standard (i.e., Institutional Settings - Transfer of Care).

4.3. The member responsible for the care of an inpatient must complete an appropriately comprehensive discharge summary in a timely manner consistent with the requirements of the institution.

4.4. Where a patient who has been seen by a member in an emergency department setting or has been admitted as an inpatient departs the institution against medical advice, the member responsible for continuing care must document:
- 4.4.1. that the patient left against medical advice,
- 4.4.2. the advice given to the patient prior to their leaving, if any, and
- 4.4.3. the reasons for departure, if known.

Standard of Practice

Maintenance of Patient Records in All Settings

Initial Approval: **Effective Date:**

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

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

PREAMBLE

This Standard sets out CPSM's requirements for maintaining patient records. It applies to paper based and digitally stored patient records, whether care is provided in-person or virtually. The requirements in this Standard are in addition to those at sections 10, 11, 13, and 14 of the *College of Physicians and Surgeons of Manitoba Standards of Practice Regulation* **("Standards Regulation"),** *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA"),** and regulations made under PHIA. The Standard is separated into five parts:

1. Terms defined for the purpose of this Standard
2. Expectations respecting other applicable authorities:
    a. *The Personal Health Information Act*
    b. Institutional legislation, rules, and by-laws
3. Custody and control of patient records (i.e., maintenance responsibilities)
    a. Responsibility for maintenance in Institutional settings
    b. Presumption of responsibility for maintenance
    c. Responsibility for maintenance in Institutional settings
    d. Transferring maintenance responsibilities
    e. Requirement for Maintenance Agreements
    f. General requirements for all maintenance arrangements
4. Requirements for maintaining patient records
    a. Security and storage measures
    b. Specific EMR system requirements
    c. Transitioning patient records management systems
    d. Retention and destruction of patient records and records of appointments
    e. Information managers
    f. Closing, leaving, or moving a medical practice

   g. Preparedness for unforeseen absence or termination of practice
5. Patient access rights and transferring patient records
   a. Patients' right to examine and copy information
   b. Transfer of patient records to third party

Note: CPSM requirements for documentation in patient records are dealt with in CPSM's **Standard for Documentation in Patient Records**.

STANDARD OF PRACTICE

Notice to the profession

The health care system shifts the standard of care in the practice of medicine over time. With this in mind, CPSM recognizes the adoption by members of Electronic Medical Records (EMRs) linked to the provincial government's electronic medical records systems (e.g., eChart, eHealth_Hub/Digital Health)[1] significantly contributes to the provision of good patient care. While working with an EMR linked to provincial systems has not yet been made a requirement in this Standard, CPSM considers this arrangement the current standard of care and it is expected that it will become a requirement pursuant to this Standard for all members when the Standard is reviewed again in or around 2026. In the interim, it is expected that all members will make efforts to adopt an EMR and establish these links as soon as reasonably possible, if they have not already done so.

1. DEFINITIONS

For the purposes of this Standard:

1.1. **"Maintain"** has the same meaning as it does in *The Personal Health and Information Act*, which is, "*in relation to personal health information, […] to have **custody** or **control** of the information.*" Respecting this Standard and relating to patient records, this meaning is expanded to include having custody or control of patient records.

1.1.1. **"Control"** means having full or partial authority and directorship over a patient record, including relating to how it is maintained. A patient record is under the control of a member when they have the authority to restrict, regulate (e.g., policy making), or otherwise administer its use, disclosure, or disposition.

1.1.2. **"Custody"** means having the protective care or guardianship of a patient record. Not to limit the foregoing, this includes having possession of a physical or virtual patient record. A person who has custody of a patient record will inherently have a degree of control over the patient record.

[1] See Shared Health's website for details regarding services offered: https://sharedhealthmb.ca/services/digital-health/ehealth-hub/

1.2. **"Abandoned"** or **"abandonment"**, with respect to a patient record, means that a trustee, as the term is defined in PHIA, has ceased maintaining the patient record in accordance with PHIA requirements without having transferred maintenance responsibilities to another PHIA trustee (e.g., the trustee is unwilling or unable to maintain the patient record).

~~1.2.~~1.3. **"Information manager"** has the same meaning as it does in PHIA, which is, "*a person or body that (a) processes, stores or destroys personal health information for a trustee, or (b) provides information management or information technology services to a trustee*".

~~1.3.~~1.4. **"Medical clinic"** means a health care facility that is primarily focused on providing medical services to outpatients, including non-institutional sole and group medical practice settings, whether incorporated or unincorporated (e.g., family ~~medicine~~doctor's office, cardiologist's office, etc.).

~~1.4.~~1.5. **"Ownership"** means, respecting a patient record, having ~~sole or joint~~certain proprietary rights to ~~a patient record or~~that patient ~~records.~~record, including rights to possession and control.[2, 3]

~~1.5.~~1.6. **"Trustee"** has the same meaning as it does in *The Personal Health and Information Act*, which is, "*a health professional, health care facility, public body, or health services agency that collects or maintains personal health information.*"

~~1.5.1.~~1.6.1. **Note:** As health professionals, members of CPSM are considered trustees pursuant to PHIA respecting any personal health information they collect and/or maintain in patient records or appointment records.

~~1.5.2.~~1.6.2. **Note:** Medical clinics fall under the definition of '*health care facility*' established at subsection 1(1) of PHIA and, therefore, are considered trustees respecting any personal health information collected and/or maintained.

2. OTHER APPLICABLE AUTHORITIES

This Standard forms only one part of the overall regulatory framework for patient records, personal health information, and other personal information in Manitoba and Canada. This Standard is not intended to comprehensively reference all enactments or rules applicable to patient records, personal health information, or other personal information established by government or institutional settings.[4]

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[2] **Note:** While a member may own or maintain a patient record, the patient has a legal interest in the personal health information contained in the record (see PHIA, *McInerney v. MacDonald*, [1992] 2 SCR 138), including certain rights to examine the record and obtain copies.

[3] **Note:** Subsection 27(1) of PHIA states that, "*No trustee shall sell or otherwise dispose of or disclose for consideration personal health information unless (a) it is essential to facilitate the sale or disposition of the practice of a health professional or the business of a health care facility or health services agency as a going concern; and (b) subject to subsection (2), the sale or disposition is to another trustee.*"

[4] **Note:** The federal ***Privacy Act*** will have application respecting personal health information collected and maintained in federal institutions (e.g., federal prisons, military bases). The federal ***Personal Information Protection and Electronic Documents Act*** ("PIPEDA") may apply with respect to the requirement to notify the Privacy Commissioner of Canada and affected individuals of any privacy breach in a private clinic that creates a real risk of significant harm to

The Personal Health Information Act

Patient records contain the personal health information of patients and the legal requirements of *The Personal Health Information Act*, CCSM c. P33.5 **("PHIA")** are applicable to that information.[5] Provisions of PHIA are referenced and incorporated several times throughout this Standard; however, this Standard does not comprehensively describe all requirements of PHIA.

2.1. It is a professional obligation that members be aware of, keep current with, and comply with PHIA's requirements for maintaining personal health information.[6, 7]

Institutional (e.g., hospital) legislation, rules, and by-laws

Institutions have legislation, rules, by-laws, and administrative services established by or for the institution to regulate and manage how personal health information and patient records are maintained. As a result, members who practice in institutional settings will generally have a limited role, on an individual level, in the maintenance of patient records within the institutional practice setting.

2.2. Members who provide either outpatient or inpatient care in an institutional setting must comply with all legislation, rules and by-laws established by or for the institution respecting maintenance of patient records.

3. CUSTODY AND CONTROL OF PATIENT RECORDS

Members are required to create patient records for the medical care they provide in accordance with the **Standard for Documentation in Patient Records**. Once created, the patient record must be maintained in accordance with this Standard, either by the member who created the record or an appropriately ~~delegated~~entrusted transferee~~.~~ (see below).

individuals. PIPEDA may also apply should personal health information fall into the custody of a commercial enterprise not defined as a trustee under PHIA. PIPEDA applies to access, use, or disclosure of personal health information over provincial or national boards. For more information about federal legislation, members may contact the federal privacy commissioner.

[5] Health, Seniors and Active Living provides useful and comprehensive information and resources, including educational materials and templates, on its website: ~~https://www.gov.mb.ca/health/phia/~~https://www.gov.mb.ca/health/phia/

[6] **Note:** PHIA is engaged when three elements are present: (1) information is considered personal health information, (2) a trustee as the term is defined under PHIA is involved, and (3) the personal health information created, used, disclosed, or maintained by the trustee.

[7] Manitoba Health, Seniors and Active Living have made training materials available online: https://www.gov.mb.ca/health/phia/training.html

Responsibility for maintenance in ~~Institutional~~institutional settings

3.1. Members who practice in an institutional setting must comply with institutional legislation, rules and bylaws respecting the control and custody of patient records that they create while practicing in that setting (see paragraph 2.2., above). Institutional settings usually take ownership of and assume responsibility for maintaining the patient records created by members who practice within the institution, though this must be confirmed by individual members.

Presumption of responsibility for maintenance

3.2. Members who practice in non-institutional settings (e.g., private medical clinics) are presumptively responsible for maintaining (i.e., ~~have~~ custody and control) the patient records that they create and their record of appointments. Paragraph 1.2.3. of CPSM's **Practice Environment Standard** establishes that:

> *If a member engages in medical care in a non-institutional setting, the member **must maintain full direction and control** of his or her medical practice, including:*
>
> > *… **documentation in, access to and security of patient records**, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient …*

3.3. Notwithstanding paragraph 3.2~~.~~. of this Standard, above, subject to a written agreement to the contrary, a member practicing as *locum tenens* is not presumptively responsible for maintaining the patient records that they create in their *locum tenens* capacity, rather the member for whom they are covering remains presumptively responsible.[8]

Transferring maintenance responsibilities

3.4. Maintenance responsibilities for patient records that are created in a member's professional practice, including those set out at Parts 4 and 5 of this Standard, may only be transferred by a member to another trustee (e.g., to another member or to a medical

[8] **Note:** Issues respecting creation and maintenance of records should be dealt with in a *locum tenens* agreement.

clinic where they practice) in accordance with subsection 11(5) of the **Standards Regulation**, which establishes that:[9, 10, 11]

> *11(5) A member **must retain control** of all of his or her patient records unless they are maintained*
>
> *(a) by **another member**; or*
>
> *(b) by **a person or organization that employed, engaged or granted privileges to the member and is a trustee** under ~~The Personal Health Information Act.~~* [PHIA].[12]

3.5. For this Standard, subsection 11(5) of the **Standards Regulation** shall be read to include the record of appointments.

3.6. For institutional settings, transfer of maintenance responsibilities will typically be dealt with contractually or in the institution's legislation, rules, and by-laws. Members working within institutional settings are expected to be familiar with these authorities.

3.6.1. If institutional maintenance responsibilities respecting patient records are not clear, the member must negotiate an agreement that makes them clear, including rules about access to and custody of the patient records.

Requirement for Maintenance Agreement[13]

3.7. For non-institutional practice settings, any transfer of maintenance responsibilities by a member respecting the patient records they will create in their practice, or their record of appointments, must be in writing ~~(i.e., a~~ ("Maintenance Agreement~~)~~")[14] and must be PHIA compliant. A Maintenance Agreement transferring maintenance responsibilities must be in place before responsibilities are transferred and must have the following components:

3.7.1. Pertinent details regarding who has ownership, control, and custodianship relating to the subject patient records.

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[9] **Note**: Accordingly, members would be prohibited from entering an arrangement in their professional practice that would violate this requirement.

[10] **Note:** This restriction applies to succession arrangements (see paragraph 4.29).

[11] **Note:** Members are strongly discouraged from transferring ownership of or maintenance responsibilities respecting the patient records they create to non-institutional health care facilities that are not controlled by another member who is also subject to this Standard.

[12] **Note:** As an example, this may include a health care facility (e.g., medical clinic) which is considered a trustee under PHIA that has employed or engaged the member.

[13] **Note:** This may form a schedule to a group practice agreement.

[14] **Note:** CPSM has developed sample provisions for Maintenance Agreements. These are available on CPSM's website at: _____ (to be developed)

3.7.2. Details about authority to access patient records in the practice setting (e.g., individuals who will be able to use the patient record).

3.7.3. Provisions to ensure reasonable enduring access related to both ~~continuity of care and patient access rights and copying rights.~~:

i. ~~Required provisions~~continuity of care, including access to discrete or limited information needed for immediate care[15], and

ii. patient access and copying rights.

3.7.4. Provisions stating that:[16]

i. the recipient trustee must give the member who created the patient record reasonable access to it to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation or review, when necessary, and

ii. if relevant, the transferring member will always have reasonable access to their record of appointments and authority to copy same for the applicable retention period.

3.7.5. Details respecting:

i. ~~Security~~security measures established by the recipient trustee that accord with Part 4 of this Standard~~.~~, and

ii. ~~Storage~~storage arrangements, including policies and procedures for the appropriate retention and destruction of patient records, that accord with Part 4 of this Standard.

3.7.6. Reasonable plans to ensure compliance with this Standard, the **Standards Regulation** and **Practice Management Standard** for the following situations:

i. The transferring member temporarily or permanently ceases practice~~,~~ or changes practice locations, including plans to notify patients how they can access and obtain copies of their patient record.

ii. The recipient trustee becomes unwilling or unable to continue to maintain the patient records (e.g., death, incarceration, etc.; see also paragraph 4.29., below).

3.7.7. Any custody and control implications upon termination of the Maintenance Agreement, if applicable, or termination of the employment, engagement, business, or practice arrangement, including implications respecting the transfer of copies of patient records (see Part 5 under the heading 'Transfer of patient records at patient's request').

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[15] **Note:** This is to survive termination of a practice arrangement, keeping in mind that subsection 22(2)(a) of PHIA states, "*A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is … to a person who is or will be providing or has provided health care to the individual, to the extent necessary to provide health care to the individual, unless the individual has instructed the trustee not to make the disclosure*".

[16] **Note:** This is to survive termination of a practice arrangement.

3.8. Regardless of whether maintenance responsibilities are transferred or not, all members who practice in a non-institutional practice setting must have a written Maintenance Agreement in place that includes the components listed at paragraph 3.7., above, respecting patient records that are created in the practice setting if one or more of the following apply:

3.8.1. The member is practicing in a setting where there are multiple contributors to a patient record (e.g., a group or interdisciplinary practice setting with a shared electronic medical record ("EMR")).

3.8.2. The member is not the sole owner of the ~~medical clinic.~~practice setting.[17]

3.8.3. The medical clinic is considered a group practice (i.e., multiple members practicing in association, in which case a ~~medical director~~Medical Director is required).

3.8.4. The member is not the sole EMR licensee relating to the patient records they create in the practice setting.

3.9. When a Maintenance Agreement is required under ~~paragraph~~paragraphs 3.7~~.~~. or 3.8, it must be in place prior to the establishment of the practice, business, or employment arrangement, or as soon as possible afterward.

3.10. For transfers of maintenance responsibilities that pre-dated this Standard or situations when a Maintenance Agreement is required under paragraph 3.8., a Maintenance Agreement that complies with this Standard must be put in place within one year of the coming into force of this Standard.

General requirements for all maintenance arrangements

3.11. The following requirements apply to **all** patient records maintenance arrangements:

3.11.1. Members who maintain patient records, including those responsible for the operation of a medical clinic that maintains patient records (e.g., ~~medical director~~Medical Director), must give the member who created the patient record reasonable access to it to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation or review, when necessary.[18]

[17] **Note:** This would apply to a health care facility or practice setting that is owned by someone who is not a member of CPSM. A practice setting may include more than one location or involve and association that provides virtual care or home visits.

[18] **Note:** PHIA provides that trustee should disclosure no more information that what is necessary to defend the action or respond to the complaint.

3.11.2. Members moving to a new practice setting who do not have custody or control of the patient records[19] of patients who choose to follow them from the former practice setting must obtain written consent from the ~~patient~~effected patients or their legal ~~representative~~representatives to transfer copies of patient records to the new location. The transfer must comply with the requirements set out under Part 5, below.[20, 21]

3.11.3. In all situations, members must prevent conflict from compromising patient care related to difficulties imposed by one member or medical clinic on another related to accessing patient records.

4. REQUIREMENTS FOR MAINTAINING PATIENT RECORDS

The requirements in this part relate to how patient records must be stored, secured, and retained over time by members who are responsible for their maintenance~~.~~ (i.e., trustees who have custody and control).

4.1. ~~In all situations, it is an overarching~~Members have a fiduciary obligation to hold patient information in confidence. It is an ethical requirement in the practice of medicine that members protect the personal information and personal health information of their patients. There is a corollary ethical duty to make proper disclosure of information to patients, including by ensuring appropriate access and copying rights.

4.1. Respecting sharing personal health information in providing good continuity of care:

4.1.1. Section 18 of CPSM's Code of Ethics provides:

> *Fulfill your duty of confidentiality to the patient by keeping identifiable patient information confidential; collecting, using, and disclosing only as much health information as necessary to benefit the patient; and sharing information only to benefit the patient and within the patient's circle of*

[19] **Note:** This occurs where maintenance responsibilities have been transferred by the relocating member to another trustee. It is noted that a transfer of maintenance responsibilities is commonly associated with a transfer of ownership.

[20] **Note:** In this scenario, the member would obtain, personally or through their staff, written consent ~~of~~from the patient to transfer ~~their~~the patient record. The written consent would then be provided to the trustee responsible for maintaining the patient record. The process at Part 5 would be followed. When moving, it is prudent to make such arrangements before relocating.

[21] **Note:** Members relocating practice must comply with all requirements set out in CPSM's **Practice Management Standard**.

care. Exceptions include situations where the informed consent of the patient has been obtained for disclosure or as provided for by law.

4.1.2. Subsection 22(2)(a) of PHIA states that:

A trustee may disclose personal health information without the consent of the individual the information is about if the disclosure is … to a person who is or will be providing or has provided health care to the individual, to the extent necessary to provide health care to the individual, unless the individual has instructed the trustee not to make the disclosure.

4.2. Members often rely on others such as~~:~~ staff, EMR service providers, or information managers to assist ~~in their patient record~~with maintenance responsibilities. ~~However, when~~When that occurs, the member ~~always~~ retains primary responsibility~~ for maintenance~~, and the expectation is that the member will reasonably satisfy themselves that the requirements of this Standard are being met~~ when others assist in maintenance~~.

4.3. Members responsible for the operations of a medical clinic that is a trustee, including Medical Directors, are deemed to share jointly with the ~~medical~~ clinic all maintenance responsibilities established under this Standard respecting the patient records that the medical clinic maintains.

Security and storage measures

4.4. A member who is responsible for maintaining patient records (*i.e., sole, or joint responsibility*) must satisfy themselves that reasonable administrative, technical, and physical safeguards are in place to protect against:[22], 23, 24, 25

4.4.1. reasonably anticipated threats to the security of patient records, including unauthorized use, disclosure, modification, or access, or any other breach of confidentiality, and

4.4.2. reasonably foreseeable events or errors that may compromise the accuracy or integrity of patient records.

[22] Guidance in this regard in provided on the Manitoba Health, Seniors and Active Living website: ~~https://www.gov.mb.ca/health/phia/resources.html~~https://www.gov.mb.ca/health/phia/resources.html

[23] See section 8 of the PHIA Regulation, which sets out requirements for periodic audit of safeguards.

[24] See section 18 of PHIA which sets out specific safeguards that must be in place.

[25] Section 6 of the PHIA Regulation requires, "*A trustee shall provide orientation and ongoing training for its employees and agents about the trustee's policy and procedures referred to in section 2 of the regulation (re security).*"

4.5. Part of safeguarding patient records will include ensuring they are stored in a safe location. Section 3 of PHIA's *Personal Health Information Regulation* establishes that trustees of personal health information are required to:[26]

4.5.1. Take reasonable precautions to protect it from fire, theft, vandalism, deterioration, accidental destruction, accidental deletion, loss, and other hazards.

4.5.2. Ensure that it is maintained in a designated area or areas subject to appropriate security safeguards.

4.5.3. Limit physical access to designated areas containing personal health information to authorized persons.

4.5.4. Ensure that removable media used to record personal health information is stored securely when not in use.

4.6. A member who is responsible for maintaining patient records must ensure that record management protocols are in place that regulate who may gain access to patient records and what they may do according to their role, responsibilities, and authority. Protocols must include:

4.6.1. Confidentiality ~~agreements~~pledges for all individuals who have access to patient records.[27, 28]

4.6.2. Controls that limit who may access and use information contained in the patient records.

4.6.3. Controls to ensure that patient records cannot be used unless the identity of the person seeking to use the information is verified as a person the member has authorized to use it, and the proposed use is verified as being authorized under PHIA.

4.7. Members must ensure the patient records they maintain (i.e., patient records for which the member is trustee) are readily available and producible when access is required~~.~~ (i.e., for PHIA authorized use). When an EMR system is used to maintain patient records, the system must:

4.7.1. Be capable of visually displaying and printing the recorded information for each patient promptly and in chronological order.

4.7.2. Be capable of displaying and creating a printed record in a format that is readily understandable to patients seeking access to their records.

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[26] See 'Examples of Commonly Used Security Safeguards' on the ~~-~~Manitoba Health, Seniors and Active Living website: ~~https://www.gov.mb.ca/health/phia/resources.html~~https://www.gov.mb.ca/health/phia/resources.html

[27] **Note:** Sample PHIA Pledge of Confidentiality available at: https://www.gov.mb.ca/health/phia/resources.html

[28] ~~Sample PHIA Pledge of Confidentiality available at: https://www.gov.mb.ca/health/phia/resources.html~~ See section 7 of the PHIA regulation.

4.7.3. Provide a way to access the record of each patient using the patient's name and health number, if applicable.

4.8. Where members choose to store patient record content that is no longer relevant to a patient's current care separately from the rest of the patient record, they must include a notation in the ~~patient~~ record indicating that ~~documents have~~information has been removed from the active patient record and the location where ~~they have been~~it is stored.[29]

4.9. Section 2 of PHIA's *Personal Health Information Regulation* establishes that trustees of personal health information must establish and comply with a written policy and procedures containing the following:[30, 31]

4.9.1. Provisions for the security of personal health information during its collection, use, disclosure, storage, and destruction, including measures

i. to ensure the security of the personal health information when a record of the information is removed from a secure designated area, and

ii. to ensure the security of personal health information in electronic form when the computer hardware or removable electronic storage media on which it has been recorded is being disposed of or used for another purpose.

4.9.2. Provisions for the recording of security breaches and corrective procedures to address security breaches, including respecting reporting obligations under applicable legislation.

Specific EMR system requirements

4.10. Members must use due diligence when selecting an EMR system or engaging EMR service providers (i.e., EMR vendor) (see also paragraph 4.26, below, respecting Information Managers when applicable) and must only use electronic patient record keeping systems that:[32]

4.10.1. comply with requirements set out in **PHIA**,

4.10.2. comply with the requirements of the **Standards Regulation**, and

4.10.3. can fulfill the requirements set out in this Standard and the **Standard for Documentation in Patient Records**.

[29] **Note:** This usually only occurs with the use of paper records.

[30] **Note:** Sample written policy available at: _____ (to be developed)

[31] See 'PHIA Policy and Procedure Requirements' on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

[32] **Note:** This can be satisfied contractually between the trustee and the service provider.

4.11. When patient records are maintained electronically, a member responsible for maintaining them must ensure that (see also 4.6., above):
  4.11.1. Each authorized user has a private and unique login identity and password.
  4.11.2. Robust security features, including encryption, use of passwords, and access controls, are in place to protect against unauthorized access.

4.12. When an EMR system is used to maintain patient records, the system must have comprehensive audit capability that:
  4.12.1. Records user activity onto a permanent log, including:
    i. the date, time, and identity of the user when patient records are accessed, and
    ii. the date and time of each information entry for every patient and the identity of the user making the entry.
  4.12.2. Indicates, in a permanent log, any changes in the recorded information and the identity of the user making the change.
  4.12.3. Preserves, in a permanent log, the original content of the recorded information when changed or updated.[33]
  4.12.4. ~~Is capable of printing~~Can print the permanent log separately from the recorded information for each patient.

4.13. Subsection 4(4) to 4(6) of PHIA's *Personal Health Information Regulation* establish that trustees of personal health information must:[34]
  4.13.1. Audit records of user activity to detect security breaches, in accordance with guidelines set by government.
  4.13.2. Maintain a record of user activity.
  4.13.3. Ensure that at least one audit of a record of user activity is conducted before the record is destroyed.

4.14. Backing-up EMRs on a routine basis and storing back-up copies in a secure environment separate from where the original data is stored is required when patient records are stored electronically.

Transitioning patient records management systems

4.15. When transitioning from one patient record keeping system to another (i.e., a paper-based to electronic system, or from one electronic system to another), members must:
  4.15.1. maintain continuity and quality of patient care,
  4.15.2. continue appropriate patient record keeping practices without interruption,

[33] **Note:** Requirements for corrections and alterations are found in the Documentation in Patient Records standard.
[34] **Note:** 'Guidelines for Records of User Activity' are provided on the Manitoba Health, Seniors and Active Living website: https://www.gov.mb.ca/health/phia/resources.html

4.15.3. protect the privacy of patients' personal health information, and
4.15.4. maintain the integrity of the data in the patient record.

4.16. To ensure the integrity of the patient record is maintained, members who are transitioning from one patient record keeping system to another must have a quality assurance process in place that includes:
4.16.1. written procedures that are consistently followed, and
4.16.2. verification that the entire medical record has remained intact upon conversion (e.g., comparing scanned copies to originals to ensure that they have been properly scanned or converted).

4.17. Members who wish to destroy original paper patient records following conversion into a digital format must:
4.17.1. use appropriate safeguards to ensure reliability of digital copies,
4.17.2. save scanned copies in "read-only" format, and
4.17.3. destroy patient records in accordance with the expectations set out in this Standard.[35]

4.18. Members who use voice recognition software or Optical Character Recognition (OCR) technology to convert records into searchable, editable files must retain either the original record or a scanned copy for the retention periods set out above.

4.19. So that complete and up to date information is contained in one central location, a member who maintains patient records and is overseeing a transition must:
4.19.1. Set a date whereby the new system becomes the official record.
4.19.2. Inform all health care professionals who would reasonably be expected to contribute or rely on the record of this date.
4.19.3. And ensure contributors only document in the new system from the official date onward.

Retention and destruction of patient records and appointment records

4.20. In accordance with subsection 11(3) of the **Standards Regulation**, members who are responsible for maintaining patient records must ensure patient records are retained for a minimum of the following time periods:
4.20.1. Respecting adult patients, 10 years from the date of the last entry in the record.
4.20.2. Respecting patients who are children (*i.e., minors*), 10 years after the day on which the patient reached or would have reached 18 years of age.

[35] **Note:** This must be considered as part of the policy trustees are required to have under section 2 of the PHIA regulation.

4.21. In accordance with subsection 10(2) of the **Standards Regulation**, members responsible for maintaining patient records must ensure the record of appointments kept for their practice is retained for at least 10 years after the date the record was made.

4.22. Members responsible for maintaining patient records must reasonably ensure that patient records and the record of appointments are maintained for the retention period in a manner that ensures these records remain reasonably accessible[36] and reproducible.

4.23. Members must only destroy patient records once their obligation to retain the record has come to an end.

4.24. When destroying patient records, members must do so in a secure and confidential manner and in such a way that they cannot be reconstructed or retrieved. As such, members must, where applicable:

4.24.1. cross-shred all paper medical records,

4.24.2. permanently delete electronic records by physically destroying the storage media or overwriting the information stored on the media, and

4.24.3. appropriately destroy any back-up copies of records.

4.25. Members who maintain patient records must ensure compliance with section 17 of PHIA, which establishes that:[37], [38]

> *17(1) A trustee shall establish a written policy concerning the retention and destruction of personal health information and shall comply with that policy.*

Information managers (see Definition, above)

4.26. Section 25 of PHIA permits trustees, including members and medical clinics, to retain an information manager to assist in maintaining patient records. Many information managers are also EMR service providers. Pursuant to subsection 25(5) of PHIA, when this occurs the patient record is deemed to be maintained by the trustee (e.g., the

[36] **Note:** For use and access that is permitted under PHIA.
[37] **Note:** Sample written policy available at: _____ (to be developed)
[38] See also section 2 of the PHIA regulation.

member, the medical clinic). Arrangements with an information manager must be in writing and accord with section 25 of PHIA:[39]

4.26.1. A trustee may provide personal health information to an information manager for the purpose of processing, storing, or destroying it or providing the trustee with information management or information technology services.

4.26.2. A trustee who wishes to provide personal health information to an information manager under section 25 of PHIA must enter into a written agreement with the information manager that provides for the protection of the personal health information against such risks as unauthorized access, use, disclosure, destruction, or alteration, in accordance with PHIA regulations.

Closing, leaving, or moving a medical practice

4.27. The **Standards Regulation** and the **Standard of Practice for Practice Management** set out important requirements for closing, leaving, or moving a medical practice. Respecting patient records, subsection 13(2)(b) of the **Standards Regulation** establishes that when a member intends to close their medical practice, take a leave of absence, relocate, or otherwise cease practice, they must notify patients, or their legal representatives, "*about where patient records are to be located, and how the records can be transferred to another member or how copies can be obtained*". **Note:** This notice requirement is obligatory regardless of whether the member is the trustee or not.

4.27.1. Per subsection 13(3) of the **Standards Regulation**, the requirements at subsection 13(2)(b) do not apply if the member's patient records are maintained by, "*a person or organization that employed, engaged or granted privileges to the member and is a trustee under [PHIA]*.

4.28. A member who closes their medical practice, relocates their medical practice, or takes a leave of absence, or otherwise ceases active practice must:[40]

4.28.1. ensure the appropriate and secure storage of any patient records and record of appointments respecting which they are responsible to maintain for the remainder of the applicable retention period, and

4.28.2. must ensure subsequent destruction in accordance with this Standard.

Preparedness for unforeseen absence or termination of practice

4.29. A member who owns or is responsible for maintaining patient records or a record of appointments must have a written plan in place to ensure the ongoing maintenance of

[39] **Note:** 'PHIA - A Trustee's Guide to Information Manager Agreements Required by *The Personal Health Information Act*' is provided on the Manitoba Health, Seniors and Active Living website: ~~https://www.gov.mb.ca/health/phia/resources.html~~https://www.gov.mb.ca/health/phia/resources.html

[40] See also subsection 14(1) of the **Standards Regulation**.

those records in accordance with this Standard that accommodates for situations where the member becomes unwilling or unable to continue to maintain those patient records (*e.g., death, incarceration, etc.*). Plans under this paragraph must be sufficient to avoid abandonment, or the risk of abandonment, of patient records or appointment records. An appropriate successor trustee must be named in the plan.[41] To be appropriate, the successor trustee must be:

4.29.1. another member; or

4.29.2. a person or organization that employed, engaged, or granted privileges to the member and is a trustee under PHIA.

5. PATIENT ACCESS RIGHTS AND TRANSFERRING PATIENT RECORDS

Patients' right to examine and copy information

5.1. Paragraph 19 of CPSM's Code of Ethics provides:

> *Provide the patient or a third party with a copy of their medical record upon the patient's request, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.*

~~5.1.~~5.2. When a member creates a patient record, the personal health information contained in the record belongs to the patient, regardless of who owns or maintains the patient record. Subsection 5(1) of PHIA establishes that, "*an individual has a right, on request, to examine and receive a copy of his or her personal health information maintained by a trustee*" subject to exceptions under which a member may refuse to provide certain information that are set out at section 11 of PHIA.[42] Respecting such requests:

~~5.1.1.~~5.2.1. Members shall make every reasonable effort to assist a patient, or their ~~designate~~legal representative, making the request and respond to it openly, accurately, and completely.

~~5.1.2.~~5.2.2. Upon receiving a request, members must, to the extent they are authorized to do so (i.e., per access rights established for the patient record), facilitate lawful access to all requested portions of a patient record, unless an exception applies, and provide copies upon request.

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[41] **Note:** An acceptable plan would include a legal instrument appointing an appropriate trustee for the member's patient records in the event the member becomes incapable of managing and maintaining the records and a legal instrument ensuring an appropriate trustee is appointed respecting the member's patient records in the event of death.

[42] See 'Your Personal Health Information – Access and Privacy Rights at our Location' on the Manitoba Health, Seniors and Active Living website: ~~https://www.gov.mb.ca/health/phia/resources.html~~https://www.gov.mb.ca/health/phia/resources.html

~~5.2.~~5.3. In accordance with sections 6 through 7 of PHIA, members shall respond[43] to a request from a patient, or their legal representative, to examine their patient record or receive a copy of it as promptly as required in the circumstances but not later than:

~~5.2.1.~~5.3.1. 24 hours after receiving it, if facilitating the response on behalf of a hospital and the information is about health care currently being provided to an inpatient,

~~5.2.2.~~5.3.2. 72 hours after receiving it, if the information is about health care the member is currently providing to a person who is not a hospital inpatient, and

~~5.2.3.~~5.3.3. 30 days after receiving it in any other case unless the request is transferred to another trustee (see paragraph 5.3., below).

~~5.2.4.~~5.3.4. In the circumstance mentioned in paragraph 5.2.1. (i.e., hospital inpatient), the member is required only to make the information available for examination and need not provide a copy or an explanation.

~~5.3.~~5.4. A member may transfer a request to examine or copy a patient record to another trustee if the information sought is maintained by the other trustee, or the other trustee was the first to collect the information. A member who transfers a request shall notify the individual who made the request of the transfer as soon as possible.

~~5.4.~~5.5. Subject to paragraph 5.3., in responding to a request from a patient or their legal representative, members shall do one of the following:

~~5.4.1.~~5.5.1. Make the patient record available for examination and provide a copy, if requested, to the individual.

~~5.4.2.~~5.5.2. Inform the individual in writing if the information does not exist or cannot be found.

~~5.4.3.~~5.5.3. Inform the individual in writing that the request is refused, in whole or in part, for a specified reason described in section 11 of PHIA and advise the individual of the right to make a complaint about the refusal under Part 5 of PHIA.

~~5.4.4.~~5.5.4. On request, a member shall provide an explanation of any term, code or abbreviation used in the patient record.

~~5.5.~~5.6. When a request is made for a patient record that is maintained in electronic form, the member shall produce a record of the information for the individual in a form usable

[43] **Note:** This would include information about whether the relevant patient record is maintained by another person, in which case the recipient of the request may not be authorized to access or copy the patient record. When this occurs, the recipient should facilitate transfer of the request to the trustee.

by the individual, if it can be produced using the member's normal computer hardware and software and technical expertise.

~~5.6.~~5.7. A member may charge a fee as permitted under section 10 of PHIA relating to a request from a patient or their legal representative to examine or copy a patient record unless the member terminated the respective patient from an ongoing practice, in which case no fee may be charged. This exception does not prohibit a member from charging a fee when the member is closing, leaving, or moving a medical practice. The fee must be reasonable and should not exceed cost recovery.

~~5.7.~~5.8. For greater certainty, a member who provides a copy of a patient record to a patient or their legal representative must retain the original for the duration of the applicable retention period.

Transfer of a copy of patient records to third party (e.g., to another member)[44]

5.9. Members must only transfer copies of patient records that they maintain to a third party, for example another member (e.g., a member who has relocated practice), when they have consent of the patient or ~~their~~the patient's legal representative or when they are otherwise permitted or required by law to do so. The following requirements apply to such transfers:

~~5.8.0.~~5.9.1. Members who have custody or control of patient records must transfer copies in a timely manner, urgently, if necessary, but no later than 30 days after a request is made. What is timely will depend on whether there is any risk to the patient if there is a delay in transferring the records (e.g., exposure to any adverse clinical outcomes).

~~5.9.0.~~5.9.2. ~~Members~~In the context of a request for a copy of the patient record (e.g., the patient is seeing another member for primary care and wants their record transferred), members must transfer copies of the entire patient record, unless providing a summary or a partial copy of the medical record is acceptable to the receiving person or the patient.

~~5.10.0.~~5.9.3. Members must transfer copies of ~~medical~~patient records in a secure manner and document the date and method of transfer in the medical record.

5.9.4. For greater clarity, a member who provides a copy of a patient record to a third party must retain the original for the duration of the applicable retention

[44] **Note:** This part relates to the transfer of a copy of the patient record and may be distinguished from requirements related to requests for a limited or discretion portion of the record for immediate care (e.g., a lab report, or pertinent encounter note).

period, unless maintenance responsibilities are expressly transferred in accordance with an appropriate Maintenance Agreement.

~~5.11.~~5.10. Fulfilling a request for copying and transferring patient records to a third party is an uninsured service. As such, members are entitled to charge ~~patients or third parties a~~ a fee. When a fee is levied, the follow rules must be followed:

~~5.11.1.~~5.10.1. When charging for copying and transferring medical records, members must:

i. provide a fee estimate prior to providing copies or summaries,
ii. provide an itemized bill that provides a breakdown of the cost, upon request (e.g., cost per page, cost for transfer, etc.), and
iii. only charge fees that are reasonable.

~~5.11.2.~~5.10.2. When determining what is reasonable to charge, members must ensure that:

i. fees do not exceed the amount of reasonable cost recovery, and
ii. correlate with the nature of the service provided and professional costs (i.e., reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting individual).

~~5.11.3.~~5.10.3. Members must consider the financial burden that these fees might place on the patient and consider whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds.

~~5.11.4.~~5.10.4. Members may request pre-payment for records or take action to collect any fees owed to them but must not put a patient's health and safety at risk by delaying the transfer of records until payment has been received.

~~For greater clarity, a member who provides a copy of a patient record to a third party must retain the original for the duration of the applicable retention period.~~

DECEMBER COUNCIL MEETING
DECEMBER 8, 2021
NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice Performing Office Based Procedures

BACKGROUND:

The development of a Performing Office Based Procedures Standard of Practice was chosen as a Strategic Organizational Priority by Council for 2020/21.

This recognized the need for CPSM to have a Standard of Practice to establish minimum practice requirements for those members conducting more complicated and higher risk medical procedures in their offices. The Accredited Facilities Working Group recommended to Council that CPSM create a Standard of Practice for Office Based Procedures. These procedures pose a higher risk to patient safety yet do not meet the threshold for accreditation by CPSM. In general, these procedures are usually not performed for medical purposes. Furthermore, many physicians performing some of these procedures are financially incentivized. This provides further rationale for regulatory rules for these procedures.

A Working Group was formed and led by Dr. Convery. It prepared a draft Standard and recommended to Council that it be circulated to the public, stakeholders, and members for feedback.

The Standard

The Standard sets out the specific office based procedures that fall under this Standard and must be performed in a medical clinic:

a. Vasectomy;
b. Male circumcision, excluding neonatal;
c. Cosmetic/aesthetic procedures which may include, but are not limited to:
    1. Application of laser energy and light-based therapies for the removal or ablation of skin lesions and pigmentation;
    2. Soft tissue augmentation – injections of fillers;
    3. Botulinum toxin/Neuromodulators - injectable
d. Procedures aimed at the treatment of known pathology may include, but are not limited to:
    1. Peripheral stem cell injection as approved by Health Canada; and
    2. Platelet rich plasma injection as approved by Health Canada.

It excludes these procedures:

a. procedures performed in a hospital or government owned or operated hospital or healthcare facility.
b. office-based ophthalmic procedures.
c. Acts that are not reserved acts under the RHPA (examples include facials, peels, microdermabrasion, micro-needling, and laser hair removal).

The Standard contains provisions for the relevant:

- Knowledge, skill, and judgment of members performing these procedures
- Safety and quality of care, including notifying CPSM about adverse patient outcomes
- Consent
- Practice management if procedures are provided by others (whether another regulated health professional or other person)
- Obligations of the medical director
- Liability coverage
- Communicating information about the procedures offered
- Honesty in financial dealing

There are also appendices that have specific requirements for injection of fillers, performance of autologous platelet rich plasma therapy, and laser safety.

This Standard will require numerous changes to their practice and processes for many of those physicians practicing cosmetic/aesthetic procedures. It also ends the ability of those physicians who act as a nominal medical director and use their MD to purchase fillers for other regulated health professionals and others to use on patients and customers outside of the physician's own medical clinic. Instead, medical directors must be present at their medical clinic regularly, have adequate QA and QI programs, and only permit regulated health professionals acting within their scope of practice to inject fillers in their medical clinics.

In creating this Standard, the Working Group benefitted by the Standards already in place in other jurisdictions and is comparable to establish similar minimum requirements for Manitoba with the Western provinces.

Consultation

At its June 2021 meeting, Council approved distributing a draft Standard to the public, stakeholders, and members. A consultation was undertaken. A notice of consultation on the Standard was sent by email to all CPSM registrants, other regulators, government, and stakeholders. An advertisement was published in the Winnipeg Free Press Saturday edition. One item in the Standard generated

much feedback and some media coverage – male circumcision – which would have important unintended consequences for the Jewish community.

Attached is the Summary of the Consultation Feedback. Also attached are all the feedback comments separated into two categories – male infant circumcision and other. In response to the enormous feedback from the Jewish community CPSM issued the attached Statement.

There were nearly 500 comments and feedback on the male infant circumcision matter, the most ever received in a consultation. A form letter (copy attached) was prepared by an organization and submitted to CPSM by 205 members of the public. Some of the public feedback was from across Canada and even International. Due to the extensive length, these comments will be sent separately to Council.

There were approximately 25 comments on other matters pertaining to the Standard.

Revisions to the Standard as a Result of Consultation

1 – *Male Circumcision* – CPSM advised the Jewish community by way of a statement that it would alter the Standard of Practice so that CPSM registrants could perform male circumcisions for religious reasons in locations other than a medical clinic.

Two changes were made to the Standard. First, it was made clear in the actual section on male circumcision that this Standard only applies to procedures performed by a CPSM member. Second, the Standard excludes neonatal male circumcision. The Jewish tradition is to perform the circumcision on the baby's eight day of life and the neonatal period is 28 days. This also aligns with the Manitoba Health Insured Benefits which includes in the tariff a fee for neonatal male circumcision.

In making this change physicians who perform male circumcisions, whether for Jewish or other religions, or traditions, whether neonatal or not were consulted. They agreed that neonatal male circumcisions could safely be performed in a medical clinic. They agreed that all other male circumcisions should be performed in a medical clinic for patient safety.

2 – *Home Office* – It was clarified that the procedures can not be performed in a home office. All procedures listed must be performed in a medical clinic.

3 – *Referral to Other Standard of Practice* – Reference is made that members must also comply with the Practice Environment Standard of Practice which has provisions that are complementary on aspects of maintaining a medical clinic.

4 – *Basic Life Support* – There is a new requirement for the medical clinic to have Basic Life support including appropriate training and certification for staff.

The Working Group discussed all other feedback, but considered the draft sent for consultation set the right touch for regulation to ensure patient safety where risks are posed.

The revisions are marked in red in the Standard.

Recommendation for Government Regulation

The Working Group made the following recommendation which was approved by Council in June 2021:

> CPSM present the Standard of Practice to the Minister of Health and Colleges for other Regulated Health Professions to recommend that other regulated health professionals and unregulated aestheticians adopt at least similar, if not higher standards of practice to ensure patient safety regardless as to who provides these procedures to ensure patient safety.

Upon approval of the Standard of Practice, the Registrar will act in accordance with this direction.

The College of Registered Nurses of Manitoba participated in the Working Group. They have advised that they are creating a Practice Direction that will be overall similar to the CPSM Standard to ensure both professions have similar minimum requirements where applicable.

Communication Strategy

- Media release

A media release to be issued on December 14, 2021 with the goal of bringing attention to what the intention of the standard is and demonstrating transparency to the public which is necessary due to the amount of responses received with this one. The release will be sent to local media. Questions and/or interviews with media may be granted if the focus serves the standard in general (and does not focus on one particular procedure).

- Email announcement from the Registrar to CPSM members
- General announcement on CPSM website
- Notification in CPSM December newsletter
- Specialized communication to list of facilities that perform the procedures listed in Appendices 1,2 and 3.

Effective Date

Given the Holiday Season, the recommended effective date of this Standard is January 31, 2022. This will permit physicians to re-organize their practices for compliance. For some physicians practicing these types of office based procedures there may be substantial work and changes to their practices to ensure compliance.

It should be noted that physicians affected by this Standard would have seen (or should have seen) an earlier version that remains largely unchanged.

PUBLIC INTEREST RATIONALE

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

As was stated to Council in June; "Some of these procedures performed by some physicians have yielded complaints and led to disciplinary actions or to criticism or advice from the Investigations Committee. CPSM has been contacted by some members seeking to understand any requirements, prior to entering a new scope of practice or business enterprise. CPSM also understands that some members have not contacted CPSM for such requirements but have merely entered into a new scope of practice or business arrangement without the required forethought. This Standard of Practice establishes the requirements for such procedures, and the Standards have been developed for the purpose of patient safety – and in the public interest, not in the interest of the practitioners.

While CPSM only governs its members, CRNM participated in the Working Group and intends to create a Practice Direction for registered nurses and nurse practitioners, many of whom are entering into these areas of practice. There are also individuals who are not regulated health professionals who may perform some of these procedures independently. It is the intention for CPSM to recommend to Government that regulation of these procedures by non-regulated health professionals occur for patient safety. Such regulation exists in some other provinces, including most recently, in Alberta."

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 8, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Council hereby approves the Standard of Practice for Performing Office Based Procedures, as attached, to be effective January 31, 2022.

Statement on concerns regarding the DRAFT Standard of Practice for Performing Office Based Procedures

Is CPSM banning circumcisions, including Jewish ritual circumcisions?

No, the College of Physicians and Surgeons of Manitoba (CPSM) is not banning male circumcisions, nor is it something we could do.

The concerning document is the DRAFT Standard of Practice for Performing Office Based Procedures. It focuses on minimizing risks associated with specific procedures performed in medical offices (i.e. office-based procedures) and establishing professional standards for communication surrounding these procedures. Among these procedures are cosmetic and aesthetic procedures, including Botox and fillers, vasectomies, laser energy and light-based therapies, and platelet-rich plasma therapy.

We recognize that as currently written, the standard would implicate a practicing CPSM member[1] performing a male circumcision outside of an appropriate medical facility. That was not the intention in drafting the standard.

All Standards of Practice[2] are released to the public for consultation and CPSM appreciates all the feedback received and concerns raised regarding this standard.

Will CPSM change the Standard of Practice?

The standard will be amended. The standard **will not** infringe on any human or religious rights and freedoms whatsoever. The role of CPSM is to protect the safety of the public, and we will continue to strive to achieve this through appropriate regulation of the medical profession.

At a minimum, the working group will add an exemption in the standard for male circumcision performed in a religious ceremony or tradition, particularly respecting low-risk neonatal circumcisions.

We are grateful for the outreach from the public in response to this standard. As with all of our public consultations, we value the feedback and will use it to improve the Standard of Practice.

[1] CPSM members include physicians, medical students, residents, physician assistants, and clinical assistants with a Certificate of Practice in Manitoba.

[2] Standards of Practice set out the requirements related to specific aspects of the quality of medicine practice. These are the rules all physicians in Manitoba must adhere to.

Who developed the Standard? Was the Jewish community consulted?

CPSM established a working group in 2020, tasked with developing a new standard of practice for performing specific procedures in office-based practice settings, including male circumcisions. The working group produced the draft Standard of Practice for Performing Office Based Procedures which was released for public consultation on June 15, 2021. The deadline for feedback is July 16, 2021.

The working group did not consult with the Jewish community in its early development of the draft Standard; however, that is precisely the purpose of the current public consultation, and we are grateful for the feedback received.

The Working Group that developed the standard included family physicians and specialists who perform the procedures, family physicians who do not perform the procedures, and a public representative. The following areas of practice were also consulted:

- Family medicine:
    - dermatology
    - aesthetics
    - vasectomy/circumcision
    - anesthesiology
    - platelet-rich plasma

- Specialties:
    - Plastic surgery
    - Dermatology
    - Hematology

The College of Registered Nurses of Manitoba was also consulted.

What happens after the consultation? When will the standard be finalized?

Understanding how various perspectives may interpret the standard is precisely why our process for developing new Standards of Practice includes a public consultation period. CPSM is appreciative of all the feedback received.

All comments will be compiled and shared with the working group. The group will review every single comment and consider the necessary amendments.

This process is in place for all CPSM Standards of Practice, many of which have significantly improved after taking public feedback into account. It is expected the standard will be in place this year.

We encourage the public to continue providing their feedback on this and other current and future Standards of Practice, available on **this page** of our website.

Comment
CPSM Members
In the standard there is reference to the following: Peripheral stem cell injection as approved by Health Canada Stem cell infusions are regulated under the Cells, Tissues and Organs regulations of Health Canada (https://www.canada.ca/en/health-canada/services/drugs-health-products/compliance-enforcement/information-health-product/cells-tissues-organs.html). The Manitoba Blood and Marrow Transplant Program is inspected by Health Canada and is accredited by the Foundation for the Accreditation of Cellular Therapies. The program currently infuses peripherally collected stem cells in undertaking autologous or allogeneic stem cell transplants. My recommendation is that peripheral stem cell injections as defined by the CTO regulations not be provided through a nonaccredited medical clinic. Over the next few years I would anticipate that more than minimally manipulated stem cell products will be commercially available some with complex genetic modification. Health Canada would approve such therapies and it would be best that such products not be routinely administered in haphazard fashion across the province in medical clinics.
I have read the standard of practice guideline. I have a concern about 1 statement in particular: The medical director must be in attendance in-person at the medical clinic for sufficient time to ensure that all their obligations are discharged satisfactorily to ensure patient safety. I am physically not at the Manitoba Clinic consistently - I would estimate I am in the Clinic anywhere from 1.5 to 3.5 days per week and not necessarily present for the entire day (ie into the later afternoon). Would this qualify as being "in-person for sufficient time"
Reviewed. No objection. Well written.
Can you clarify the following: In the new policy, it states in the Preamble: **Medical clinic** is defined as a medical care facility that is primarily focussed on providing outpatient medical care by CPSM members and includes what is commonly known as a physician's office. It does not include a non-medical aesthetic clinic, medi-spa, lash bar, residence, or hospitality facility. Then in clause 2.1, it states: 1. 2.1. Members must not perform, or cause, permit, or enable another person to perform, any procedure in a location other than in a medical clinic. What is the definition of a medical clinic? What about medical clinics that operate WITHIN say grocery stores (ex. Superstore) or within beauty industry venues ex. lash bars, salons, etc? In the college's own bylaws under Standard of Practice Environment, it states: 1. Medical Practice in Non-Institutional Settings 1.1. If a member establishes a medical practice in a non-institutional setting, the premises in which the medical care is provided must be safe, appropriate and sanitary. 1.2. If a member engages in medical care in a non-institutional setting, the member must maintain full direction and control of his or her medical practice, including: 1.2.1. The medical care provided to or for a patient;

1.2.2. The safety quality of the premises in which the member practises and of the equipment and the supplies used, including proper maintenance, cleaning and calibration of equipment used in the medical care her or she provides;
1.2.3. documentation in, access to and security of patient records, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient;
1.2.4. any advertising of or for the medical practice;
1.2.5. billing for any medical care that is not an insured service under The Health Services Insurance Act; and
1.2.6. the qualifications and performance of each staff member supervised by the member.
1.3. A member is not required to own any supplies, equipment or premises used by the member in a medical practice.
1.4. A member who practices in a non-institutional setting and who does not own the supplies, equipment or premises used in that practice must:
1.4.1. promptly notify the owner if one or more of the supplies, the equipment or the premises impede the member in providing safe medical care;
1.4.2. not provide any specific medical care which cannot be safely provided with the available supplies, equipment or premises.
1.5. A member who removes tissue from a patient in a non-institutional setting, must forward the tissue to an accredited laboratory for examination applying the same standards as required for tissues removed in hospitals.

Additionally, personal residence is listed as a practice location in 1.6:
1.6. In the event of an on-site audit of a member who has designated his or her home address as his or her primary practice location, that member shall be responsible to demonstrate to CPSM that the member has access to equipment appropriate to the practice of medicine and to clinical records reflecting the patient care provided by that member.

There is also a section on non-medical settings and medical directorships in section 2:

2. Non-Institutional Setting: Medical Director
2.1. A member must not practice in any non-institutional setting where two or more physicians practice together, irrespective of the ownership of the non-institutional setting unless the non-institutional setting has a duly qualified medical practitioner in good standing designated as "Medical Director".
2.2. The Medical Director must: 2.2.1. ensure that only qualified members provide medical care in the non-institutional setting;
2.2.2. ensure that, regardless of the name of the non-institutional setting, the name(s) of all the physician(s) and medical corporations are clearly posted, either on the exterior of the non-institutional setting or in the reception area;
2.2.3. ensure that the non-institutional setting complies with the Code of Ethics;
2.2.4. ensure that all communication about the patient is through or on behalf of the appropriate attending member;
2.2.5. be responsible for and have authority over all aspects of non-institutional setting operation which can affect the quality of patient care.

I'm trying to reconcile this new bylaw with our previous practice location bylaw, and I must be missing something because it sounds like this new bylaw would limit doctors in where they can practice even if that location was adhering to the standards of practice location. Additionally, this would only apply to aesthetics (filler, neuromodulators, lasers, PRP), vasectomies etc but more invasive procedures (ex. Mirena insertion or home intravenous antibiotics) could be done in any setting?

SECOND SUBMISSION

The College has identified that a standard for minimum practice requirements is necessary in the field of aesthetics and is congratulated for taking on its creation. Because aesthetics is often more elective, competitive, and profit driven as an industry, the College should be careful (as a self-governing body) to be certain this essential policy is crafted in a constructive way. Specifically, the focus must remain on addressing the issue of patient safety and how best to achieve this goal. The College cannot be used as an instrument to serve anti-competitive practices by implementing policies that favor one member over another, or by limiting the scope of physicians whereas the field of aesthetics is practiced by other advanced providers not subservient to the College's authority.

ISSUE I: STANDARDS

Training standards must be put into place. Currently, there is a lack of consistency, quality, and authority in the aesthetics industry revolving around aesthetic-based education. Weekend courses, M.D.s being taught by LPNs, and profit driven seminars inter alia are predatory and undermine the ethics and traditional education to which M.D.s are subject. The college should stipulate the following:

1. Training must not be solely from industry specific sources. (This is in line with the long-standing constraint on physician/pharmaceutical representative relationships.)
2. A minimum of training provided directly by a physician and not a proxy.
3. CME credits should be considered that the supervising physician must attend personally.
4. Proficiency in a procedure must be demonstrated. (Currently, certification is granted on a "payto-play" model.)

A comprehensive list of safety standards better suits the College's goal while ensuring the new policy remains consistent and uniform with College Standards of Practice approved January 1, 2019. The college should stipulate the following:

1. A health care worker with current/active ACLS must be on-site when any level 2 procedure is taking place in adherence with the MedSpa level 2 designation (ex. neuromodulators or dermal fillers).
2. The supervising physician is required: (a) have up-to-date ACLS, (b) themselves demonstrate proficiency and competency in the procedure they are supervising or delegating, (c) craft standard protocols for emergencies, and (d) supply product and instruments to address those emergencies.
3. Any M.D. using their license as a medical director **must** demonstrate the process of supervision in the form of cosigned notes or other documented review processes.
4. Given the importance of photography in the practice of medical aesthetics, an electronic medical record to protect patient privacy in compliance with PHIA should be standard. **S.** Ultrasound guidance in the use of dermal filler should be the rule not the exception.

ISSUE II: LOCATION OF PRACTICE

The College has already put into place a standard of practice for medical practice in non-institutional settings (see The College of Physicians & Surgeons of Manitoba Standard of Practice, Practice Environment, Effective date: January 1, 2019). The proposed policy is redundant as well as contradictory (in part) with this pre-existing standard. Specifically, the proposed policy restricts less invasive, less complicated, and less dangerous elective aesthetic procedures while the existing CPSM SOP, Practice Environment permits more intrusive, more complex, and more aggressive medically necessary procedures (i.e. intravenous antibiotics for chronic wounds, peritoneal dialysis, or complex dressing changes). In fact, the proposed policy in effect reduces physician scope while not guaranteeing enhancement to the College's primary concern which is patient safety.

Explicitly, the proposed policy does not address the following:

1. Nurse Practitioners and Nurses are not bound to this same standard and have the potential to more aggressively expand and compete in the aesthetic market untethered to Physician oversite and acting in defiance to the College's patient safety concerns. See below:
   a. Jessica Jacob N.P., "The Injection Nurse," operates in Winnipeg, MB, trains Physicians, RNs, and LPNs and promotes herself more as an influencer than a professional medical provider.
   b. THMA Consulting is run by Tracey Hotta RN, who publicly holds herself out as a "Medical Aesthetics 'Provider' and Trainer." (see https://thmaconsulting.com/).
   c. Vivify — Beauty on the Go is an NP owned and led mobile aesthetics, operating out of client's personal residences with no guarantee of sanitation or safety.

2. Restricting members practice location only to a medical clinic as defined in the proposed SOP Preamble does not guarantee any additional safety or sanitary environment above or beyond the existing CPSM SOP, Practice Environment Standard 4(1) & 4(2):
   a. 4(1) A member may engage only in medical care that, in the member's reasonable and professional judgment, is safe, appropriate and sanitary.
   b. 4(2) A member must take reasonable steps to ensure that a system is in place for the proper maintenance, cleaning and calibration of equipment used in the medical care he or she provides.

3. Medical Aesthetics is a profit driven industry, many non-institutional settings exceed standards of traditional medical clinics. Furthermore, the College has already and adequately addressed the concern of medical practice in non-institutional settings see CPSM SOP, Practice Environment Standard 1:
   a. 1.1. If a member establishes a medical practice in a non-institutional setting, the premises in which the medical care is provided must be safe, appropriate and sanitary.
   b. 1.2. If a member engages in medical care in a non-institutional setting, the member must maintain full direction and control of his or her medical practice, including:
      i. 1.2.1. The medical care provided to or for a patient;
      ii. 1.2.2. The safety quality of the premises in which the member practices and of the equipment and the supplies used, including proper maintenance, cleaning and calibration of equipment used in the medical care her or she provides;
      iii. 1.2.3. Documentation in, access to and security of patient records, including documenting medical care provided to a patient, patient appointment schedules, patient billing and payment records for the medical care of a patient;

1.2.4. Any advertising of or for the medical practice;

iv. 1.2.5. Billing for any medical care that is not an insured service under The Health Services Insurance Act; and
v. 1.2.6. The qualifications and performance of each staff member supervised by the member.

c. 1.3. A member is not required to own any supplies, equipment or premises used by the member in a medical practice.

d. 1.4. A member who practices in a non-institutional setting and who does not own the supplies, equipment or premises used in that practice must:
i. 1.4.1. promptly notify the owner if one or more of the supplies, the equipment or the premises impede the member in providing safe medical care;
ii. 1.4.2. not provide any specific medical care which cannot be safely provided with the available supplies, equipment or premises.

e. 1.6. In the event of an on-site audit of a member who has designated his or her home address as his or her primary practice location, that member shall be responsible to demonstrate to CPSM that the member has access to equipment appropriate to the practice of medicine and to clinical records reflecting the patient care provided by that member.

ISSUE III: CONFLICT OF INTEREST

As a self-governing body CPSM must ensure policies achieve goals without undue burden to member's ability to practice. Policies that are incongruent with existing policies, or policies that are put into place to promote one member's practice over another's **must** not only be carefully crafted but also **necessary.**

If the College seeks to implement the proposed policy as written, it should at a minimum present the following:

i. Case studies evidencing patient complications arising from medical aesthetics performed by members already adhering to CPSM SOP, Practice Environment Requirements for Practice Environment in non-institutional settings.
ii. Disclosure of any and all contributors who advised, petitioned, and/or drafted the proposed policy as well as a declaration of any conflicts of interest (ex. owning a large, established medical clinic that deals in aesthetics).
iii. An explanation as to how limiting M.D.s will have any effect at addressing patient safety in medical aesthetics when NPs are not and will not be held to the same standard.
iv.

CPSM is attempting to regulate aspects for the quality of practice of medicine in aesthetics. This is both necessary and long overdue. Because medical aesthetics is largely an elective and for-profit enterprise, the College **should not** be used as a tool to stifle competition. Instead, the policy must favor skill and acumen while driving ethics and promoting physician judgment. Patient safety can be achieved by ensuring **(1)** enhanced standardized training, **(2)** standardized oversight, **(3)** electronic medical records, and **(4)** advanced instruments. The foregoing more than adequately addresses the College's concerns while not diminishing Physician authority or scope of practice

I think the College ought to use consistent language around evidence based medicine.

Evidence has a very specific meaning related to observation and the scientific method. A number of systems have been proposed to communicate levels of evidence such as the GRADE criteria. I think that the College ought to identify one and use it consistently.

The proposed Standard of Practice Performing Office-Based Procedures uses the term "Evidence Informed". It is not clear how this relates to accepted levels of evidence, or to the Standard of Practice on Good Medical Care. Currently the Standard of Practice on Good Medical Care discusses Non Traditional Therapies. The relationship between the term "non traditional" and evidence is also not clear.

The public is best served if physicians promote interventions with strong evidence of patient benefit, discuss the pros and cons of interventions with modest evidence, and warn patients when the intervention under discussion has minimal supporting evidence. When the evidence of benefit is minimal and there are clear harms (including financial harms) physicians should not be prescribing, condoning, or promoting an intervention. The profession takes considerable care to categorize interventions based on evidence of benefits and harms. The College should not attempt to cloudy the waters by using terms such as evidence-informed or non-traditional. Those are terms promoted by persons who are attempting to skirt discussions of evidence - often in an attempt to exploit patients. Clarity is in the interest of patients and patient safety.

: 2.1. Members must not perform, or cause, permit, or enable another person
to perform, any
procedure in a location other than in a medical clinic.

Re: Male circumcision:

The ritual performance of circumcision has been shown over many years to be safe when performed by qualified practitioners in community settings.

While I generally support the need for this standard of practice and its content, I suggest male ritual neonatal circumcision be excluded as it has been shown to be a safe procedure in community settings.

I would like to lend my voice to the concern regarding removing Ritual and even non ritual circumcision from the office ,clinic or even the home .
I have attached the letter of concern from the Winnipeg Jewish Community

In the past I have performed hundreds of Ritual circumcisions in the parents home or in the synagogue using Sterile Equipment ,Sterile technique and a local Block with no adverse effects .
I understand the college's concerns however i don't believe they are well founded if they are done by trained ,careful ,and skilled practitioners.
.My concern and the reason I became involved in the past was that there were several Lay Religious members performing "Brit Milah "that were having some complications .I was also seeing complications related to ritual circumcisions performed by lay practitioners in the Muslim community and others .I know of no major complications related to non ritual procedures performed by skilled and careful physicians out of the hospital or credentialed procedure rooms .
I would suggest that the college consider the following

- Investigate and recommend the best techniques and instrumentation to be used for these procedures .
- Develop credentialing criteria for physicians wishing and willing to perform circumcision in the community
- Look at the college mandate regarding investigation and credentialing lay practitioners
- Identify the physicians in Manitoba involved in the community ,meet with them and develop a strategy to continue with this service.

I will be happy to help in any way.

Proposed draft for standard of practice for office procedures has few areas of concerns:

1) Family physicians across country provides many highly skilled procedures for example intubation, fracture reduction or putting central line- as to do certain jobs it may require years of training in respective specialties. For example for intubation one needs to go in Anesthesia program.

However there are no stringent rules listed for practice guidelines for family physicians where high level of skill required.
A doctor can practice as per his or her training and experience in most circumstances.

2)Training required for such office based training in proposed draft is ambiguous.

- There are numerous spas , hair salons across province of Manitoba provide neuromuscular, laser and Fillers injections without on site medical director. nurses providing fillers, neuromuscular injections at their clients homes, without any supervision. CPSM's regulations will not affect other beauty industry or nurses. However putting stringent and unclear training requirements may deter many physicians to provide such office based elective procedures, who actually can provide such services safely. Physicians other then dermatologist can deliver such minimal invasive procedures in much safe, clean and controlled environment, with minimal training.

-CPSM is asking Physicians to contact medical education / Medical school medical school to get equvellency in Dermatology for such minimal invasive medical price is unexceptable requirement. As a physician we get detail through training in Anatomy and various injection techniques throughout medical education.

Learning Neuromodulator, PRP , filler or laser required some extra training to be aware of technique, side effects and complication management.
Everything we do in Medicine unfortunately can have dreaded life threatening complication including as simple as writing a medical prescription.

3) For nurse injector working in North of Manitoba, May not find any medical director to work with them on site. To allow them to have a medical director who can overlooks a nurse's work(who has appropriate training) and provide consultation on virtual method should be allowed . As some nurse are highway train can perform such procedures with minimal or no supervision.

Establishing guidelines is a good policy, however for safety of patients in Manitoba, allowing asthetic minimal invasive cosmetic procedures or treatment by physicians should be encouraged rather putting threatening and unclear rules . A medical doctor can deliver such procedures in safe environment. If CPSM Requires doctors to do enhenced training or plus one in dermatology, many physicians will not be able to get such training options and nurses or other beautician/ aesthetician will benefit at coast of patients safety and bad outcomes, where CPSM Will not have any control.

I have read the guidelines on Performing Office-Based Procedures. I feel that the clause in 2.1 of the draft, where it is noted that "members must not perform, or cause, permit, or enable another person to perform any procedure in a location other than a medical clinic" should not be applicable with respect to the performance of the Bris or Brit Milah procedure. As you may know, the Jewish Federation has drafted a letter regarding this issue which I have read and signed. I am hopeful that the guidelines will be modified to exempt this religious practice.

In the main, the standard seems reasonable and clear. I do have some concerns and questions regarding routine circumcision.

1. There is no reference in the standard to the question of the appropriateness of newborn circumcision. Although still controversial for some, The Canadian Pediatric Society reaffirmed in January, 2021 its position in 1996 that it does not recommend the routine circumcision of every newborn male. This policy is based on a closely balanced risk:benefit ratio. This is problematic because of the ethical matter of informed consent by a parent for a permanent change of their Child's body. Such decisions (e.g. vaccination and medical treatments) are expected of parents because of their medical necessity or established favourable risk:benefit ratio. These criteria do not appear to be met for routine neonatal circumcision.

2. Although usually more invasive, anatomically mutilating, and with more significant complications, the ethical principles which apply to female genital cutting are similar. As specified in our SOP, members must not perform FGC. Performing this on a minor is child abuse and with some exceptions would be viewed as a criminal act of aggravated assault.

3. Knowledge 1.2 states that members must recognize when "patients are not suitable to undergo the procedure,…". It is not clear to me what the scope of this statement includes for circumcisions. Is it only contraindications such as significant bleeding disorders or anatomical abnormalities? Or does it include indications for a medically necessary or medically beneficial procedure? According to the CPS statement, routine neonatal circumcision - in the absence of a specific indication - would not be considered as a suitable procedure for most patients, with or without the consent of their parent(s).

4. Knowledge 1.4 requires members to practice "evidence-informed medicine". Perhaps the CPSM should have a standard for routine circumcision, regardless of where performed, to require the member to record the medical indications for the procedure. If such indications in the opinion of the member are inconsistent with "widely accepted views of the profession", Code of Ethics #41 requires the member to indicate that to the patient/parent. Perhaps it should also be a requirement to document that in the medical record.

5. Communication (7.2) may be especially challenging for procedures carried out for religious or other cultural reasons. Perhaps there should be standard information sheets provided to parents explaining risks and benefits, the statement of the CPS, and that the member's opinion about routine circumcision is inconsistent with the CPS and other credible authorities.

I agree with the importance of safe settings and circumstances for procedures of this type. I suspect that members who do routine circumcisions will, if they haven't already, create settings that can accommodate families and friends in a ceremonial ritual while complying with all conditions of these new standards.

I remain concerned, however, that this standard, as written, implies approval by CPSM of routine neonatal circumcision. It is a reserved act, routinely performed without anesthesia or analgesia in the archaic tradition, permanently altering the normal anatomy without consent of the person that cannot reverse the decision, and perhaps most importantly, without evidence of medical net benefit.

Perhaps these issues are separate from the purpose of this standard and should be reviewed independently. Regardless, I hope that some of my comments are useful.

I would like to provide feedback relating section 2. Safety and Quality of Care of the proposed Standard of Practice relating to Standard of Practice for Performing Office-Based Procedures, specifically sections 2.1 and 2.2
2.1. Members must not perform, or cause, permit, or enable another person to perform, any procedure in a location other than in a medical clinic.
2.2. Members must only perform procedures in a medical clinic that is safe, appropriate, and sanitary, is suitably equipped and staffed, and complies with any relevant regulatory requirements, and the Infection Prevention and Control for Clinical Office Practice.

These two stipulations are not consistent with the goal of high-quality care as defined by the Institute for Healthcare Improvement's six dimensions of quality.

There are several procedures that can be completed safely and sanitarily in settings other than a medical clinic. As a physician that both provides home visits and several procedures as part of my practice including male newborn circumcision, it is my understanding that medical care and procedures can be conducted in a high-quality manner consistent with the "Good Medical Care" Standard of Practice outside of a medical clinic.

Moreover, it is my opinion that several dimensions of quality can be more consistently achieved in home settings, in particular male newborn circumcision. Specifically, patient-centred care, timeliness and efficiency are all achieved more readily by providing male newborn circumcision in the comfort of a parent's home than in a clinic. With regards to effectiveness and safety, my anecdotal experience and a brief review of the literature demonstrate that home versus clinic-based options are equivalent. Lastly, with regards to equity one could make a salient argument that the restriction of a medical act with historical and religious significance (i.e. home-based male newborn circumcision) would negatively and disproportionately impact those of the Jewish faith.

Thus, it is my opinion that the application of sections 2.1 and 2.2 would on balance negatively impact health care quality and should be amended. I would propose completely removing section 2.1 and alter section 2.2 to change the phrase, "in a medical clinic that is safe, appropriate, and sanitary…" to the following, "in an environment that is safe, appropriate and sanitary…".

I am writing to express concern about the inclusion of male circumcision in the standard. I am a Jewish physician and ritual circumcision is required at 8 days for all newborn Jewish males. This has been a standard practice for thousands of years normally done in the home or the synagogue. It is done as part of a religious ceremony. I don't feel that the College can now mandate that this religious ceremony can only take place in hospitals or medical offices. I think this would be challenged under the Charter of Rights and Freedoms as violating religious freedom. To my knowledge there haven't been any medical problems with Jewish circumcisions for decades so it's not clear to me why the College feels it must regulate a practice. This procedure has been performed in the past sometimes by a physician and sometimes by a rabbi or other trained non-physician member of a congregation of worship. I don't see that the College can decide on the scope of practice of non-physicians unless it can provide compelling evidence of harm. I do feel that the College can set standards for physicians about circumcision but I feel that the College should also respect religious beliefs and define ways for physicians to do this safely in baby's homes or the synagogue as well as private medical facilities and hospitals.

July 16, 2021

STANDARD OF PRACTICE –PERFORMING OFFICE-BASED PROCEDURES (INCLUDING COSMETIC/AESTHETIC AND MINOR SURGICAL PROCEDURES, PLATELET-RICH PLASMA THERAPY, AND LASER DEVICE)

Consultation to Members, Stakeholders, and the Public Introduction

This Standard has been created to establish minimum practice requirements for complicated medical procedures performed in offices or medical clinics (office-based procedures). These types of procedures pose a higher risk to patient safety

THE STANDARD

1. Application of laser energy and light-based therapies for the removal or ablation of skin lesions and pigmentation Suggestion: exclude application of lasers and energy-based devices for intraoral / oropharyngeal treatment (i.e. including but not limited to vascular malformations, snoring or skin-tightening) which should be governed by the **Accredited Facilities Bylaw.**

PREAMBLE

The College of Physicians and Surgeons of Manitoba sets standards that establish expectations for quality care for patients regardless of whether the care provided is medically required or purely elective. Many members perform various in-office procedures on their patients that are medically required or elective. Some of this care is provided in non-hospital medical or surgical facilities and is therefore governed by the Accredited Facilities Bylaw. However, many procedures are performed in non-institutional settings such as established physician offices or medical clinics. When providing this care, members must comply with this Standard. Medical clinic is defined as a medical care facility that is primarily focussed on providing outpatient medical care by CPSM members and includes what is commonly known as a physician's office. It does not include a non-medical aesthetic clinic, medi-spa, lash bar, residence, or hospitality facility, (**Suggestion to include**) unless approved by College Registrar

APPLICATION

2. Safety and Quality of Care

2.6 An adverse patient outcome is defined as an unanticipated significant outcome, either by misadventure, complication, or patient reaction that requires higher level care by an alternate CPSM member and includes but is not limited to:

2.6.1.Transfer to hospital or unanticipated follow-up at a hospital related to how the procedure was performed or how the patient responded to the procedure;

2.6.2.Third degree burns, disfigurement, or impairment of vision;

2.6.3.Extreme pain or discomfort causing significant limited function in an ongoing fashion;

2.6.4.Intra-arterial injection resulting in thrombosis, tissue ischemia, necrosis, or embolism with risk of blindness;

Comment:

i) Vision Impairment or Mono-ocular Blindness: This is extremely rare and infrequent but indeed a tragedy. Good technique and knowledge of injection anatomy is required. *There were 48 cases of blindness following filler treatment reported in the world literature between January 2015 – September 2018, out of approximately 9.5 million cosmetic filler procedures performed in the United States.]

*Aesthetic Surgery Journal 2019, Vol 39(6) 662–674
www.aestheticsurgeryjournal.com

Unfortunately, this rare complication occurs

ii) **Question to CPSM committee:** Vascular occlusion are rare adverse event. This event is treated and reversible.
Does a recognized vascular occlusion treated in office without sequelae require reporting to CPSM?

5. Obligations of Medical Director

5.2 The medical director must ensure that the medical clinic, or members or other persons performing procedures do not function to increase profit at the expense of good medical care.

5.4. Members must only be medical directors of medical clinics in which they actively practice. Members must not be medical directors of non-medical clinics or other entities.

5.5. **(Suggested addition**) Members must have CPSM approval to act as a Medical Director

APPENDIX 1 –INJECTION OF FILLERS –SOFT TISSUE AUGMENTATION AND BOTULINUM TOXIN/ NEUROMODULATORS

Question and comment to Committee:

Should a member be required to notify CPSM with a change in their scope of practice to include medical aesthetics?

Should a member wishing to change scope of practice to include medical aesthetics provide documentation and acquired qualifications, skills and knowledge?

See CPS of Sask POLICY Performing Office-based Non-insured Procedures; change in their scope of practice for Medical Aesthetics

1. In addition to complying with the above Standard of Practice requirements, members who provide, authorize, delegate, or enable injections of botulinum toxin, dermal fillers, fillers of any sort injected below the dermis, or neuromodulators, controlled products, of other injectable cosmetic substances (all defined as substances) must comply with this Appendix.
2. .Members must ensure only substances approved by Health Canada are injected.
3. .Members who inject substances must have completed relevant and significant procedure specific medical education and training prior to performing such procedures.
   Comment: Needs clarification to what is required by member. Please clarify what is meant by "completed relevant and significant procedure" (See Appendix A CPS Sask Policy).

4. Members must not themselves, nor may they permit or enable any other person to
   inject these substances in a location other than their medical clinic and then only as part of good medical care.

5. Members may permit a regulated health professional acting within their scope of practice to inject these substances in their medical clinic. Members must not permit or enable any other persons to inject these substances.
6. .Members must not authorize the purchase, distribution, or dispensing of these substances, for use by other persons outside their medical clinic, whether regulated health professionals or not.

6.1 (**CONSIDER Adding**) Members must not authorize, attend or permit 'Botox parties' or similar like events, home treatments or demonstrations within lash bars, spas, salons or similar like venues.

7.Members must perform an assessment and provide a client specific order for Schedule 1 drugs under the Controlled Drugs and Substances Act when collaborating with a regulated health care professional to administer the drug where that regulated health care professional is not authorized to prescribe.

Question : Are there circumstances that a controlled Schedule 1 Drug be administered in NON Accredited Facility?

8.Members must have appropriate antidotes present when a performing these injections.

9. **Consideration to include:** Members with a recent authorized scope of practice must keep a log of all injections for a period of 1 year to submit to the College if asked.

APPENDIX 3 –LASER SAFETY

1. In addition to complying with the above Standard of Practice requirements, members who use a laser device for patient care and/or treatment must comply with this Appendix.

2. Members who use a laser device for patient care and/or treatment must have completed relevant and significant specific laser operation education and training prior to performing procedures with a laser

(**Consider adding**) or delegate treatment or act as Medical Director for lasers or Energy based devices used in medical clinic without said training and education.

Relevant and Significant Training

Patients are entitled to receive safe medical care by knowledgeable, skillful, and competent medical practitioners. Many procedures are performed by plastic surgeons or dermatologists, or family physicians with an added competency, (**Consider adding)** with the latter members confirmed and authorized by CPSM or Registrar.

While many years of training is not required for every procedure, a weekend course(s) is not sufficient for family physicians, other regulated health professionals or staff in the medical clinic performing or participating in the procedures (Comment: Consider rephrasing. The statement is too broad as worded with regard to what should be required). (See Appendix A CPS Sask Policy).

It is incumbent upon members to ensure their knowledge, skill, judgment, and competency prior to performing any procedures. This is an objective, not subjective standard. Members should take numerous courses and perform a number of procedures under supervision prior to performing procedures independently to ensure they will provide good medical care to their patients.

CPSM can not establish what is the exact training or courses required for each member to determine knowledge, skill, judgment, and competency. The training is dependent upon the procedure to be performed, the education, scope of practice, specialization, and experience of each physician. CPSM can only say that the training must be relevant and significant and that members should seek to invest both the time and cost to establish the required knowledge, skill, judgment, and competency.

[**Comment:** CPSM should establish training and certification requirements are needed. There are many Society, Association Meetings and Programs recognizable by the CPSM as well as CME available for training. The committee should consider asking injecting members of the Dermatology and Plastics Community for listing of such meetings].

Change in Scope of Practice for Medical Aesthetics

Applicants are responsible for submitting the required documentation to the College of Physicians and Surgeons to evaluate skills and qualifications for scope of practice change requests related to aesthetic and cosmetic medicine.

Required Qualifications

1. Use of Neuromodulators (Injectable)

- Evidence of didactic training in facial muscle anatomy and the basic science of neuromodulators.
- Completion of 16 documented hours in sessions focusing on the use of neuromodulators.
- Performance of at least 3 neuromodulator injections under direct supervision.

These are the basic requirements to incorporate the practice of cosmetic injections of the face only.

Documentation of additional training and experience may be required to use Botox™ for medical purposes such as hyperhidrosis, migraine therapy, bruxism and TMJ.

2. Soft Tissue Augmentation (Injection of Dermal Fillers)

- Evidence of didactic training in facial anatomy and the basic science of soft tissue augmentation.
- Sixteen (16) documented hours in sessions focusing on the use of soft tissue fillers. (These hours can overlap with anatomy and basic science of neuromodulators)
- Performance of at least 5 soft tissue augmentation injections under direct supervision

3. Light and Laser Based Technologies (To Maintain/Improve Skin Health/Skin Tightening/Body Contouring/Tattoo Removal/Hair Removal)

- Evidence of didactic teaching in the basic science of light/laser technologies and the interaction between light/laser energy and the skin.
- Sixteen (16) documented hours attending sessions focusing on the basics of light/laser technology.
- Documented evidence of training on the device(s) that the practitioner will be using.
- Three (3) documented completed cases on the device(s) the practitioner will be using.

4. Hair Transplantation

- Documented evidence of didactic teaching in the anatomy/histology and physiology of hair and scalp, the physiology and pharmacology of local tumescent anesthesia, safety and complications, and discussion of surgical technique.

- Twenty-four (24) accredited and documented hours in the basic principles of hair transplantation.
- Completion and documentation of an accredited hands on course in hair transplantation.
- Current Basic Cardiac Life Support (BCLS) certification.
- Three (3) documented cases of hair transplantation completed by the practitioner.

5. Invasive Body Contouring (Liposuction) Using Tumescent Technique, Powered, Ultrasonic, Laser, Radio-Frequency, Water Jet, or Equivalent Technologies

- Documented evidence of didactic teaching in the anatomy/histology and physiology of adipose tissue, the physiology and pharmacology of local tumescent anesthesia, the physiology and pharmacology of fat removal, safety and complications, and discussion of surgical technique.
- Twenty-four (24) accredited and documented hours in the basic principles of invasive body contouring.
- Completion and documentation of an accredited hands-on course in invasive body contouring.
- Current Advanced Cardiac Life Support (ACLS) certification.
- Documented training on the invasive body contouring device(s) the practitioner will be using.
- Three (3) documented cases completed on the device(s) the practitioner will be using.
- Additional facility approval and accreditation may be required, depending on the setting in which the service will be provided.

6. Evidence of appropriate training and experience will be reviewed on a case by case basis for additional procedures such as:
- Sclerotherapy
- Injection of platelet rich plasma (PRP)
- Injection of mesotherapy agents
- Other invasive aesthetic or cosmetic procedures

These qualifications are based on standards in other jurisdictions as well as training/certification programs available for physicians. Some didactic components may be combined when basic science and anatomy are related.

These requirements may be updated as the practice of aesthetic medicine changes.

POLICY

Performing Office-based Non-insured Procedures

STATUS:	APPROVED
Approved by Council:	September 2018
Amended:	n/a
To be reviewed:	Sept. 2021

PREAMBLE

The College of Physicians and Surgeons of Saskatchewan (CPSS) has the authority to set standards and policies that establish expectations for high quality care for patients regardless of whether the care provided is medically required or purely elective. In the past number of years, there has been considerable growth in the industries that provide cosmetic/aesthetic care to patients and also procedures aimed at the treatment of pathology that are not considered mainstream or have not traditionally been insured services. While some of this care is provided in non-hospital treatment facilities (NHTFs) and is therefore governed by Bylaw 26.1, many procedures are performed in non-institutional settings such as physician offices and med-spas (a "clinic" or "clinics"). When providing these types of care, physicians are expected to comply with policies and procedures that maximize the likelihood of safe and effective patient care.

This policy is intended to apply to the office-based provision of cosmetic/aesthetic procedures and also non-insured procedures aimed at the treatment of pathology. Examples of cosmetic/aesthetic procedures may include, but are not limited to:

1. Application of laser energy and light-based therapies;
2. Hair transplantation;
3. Use of neuromodulators (injectable); and
4. Soft tissue augmentation (injection of dermal fillers).

Examples of non-insured procedures aimed at the treatment of pathology may include, but are not limited to:

1. Peripheral stem cell injection; and
2. Platelet rich plasma injection.

For the purpose of this policy, these and any other comparable non-insured procedures are referred to as a "procedure" or "procedures".

Reference to any specific non-insured procedure in this policy does not imply endorsement by the CPSS. Physicians are cautioned to ensure compliance with the CPSS policy "Complementary and Alternative Therapies."

POLICY

1. Knowledge, skills and performance

1.1. Physicians are responsible to recognize and work within the limits of their competence, and to refer a patient to another practitioner if they cannot safely meet the patient's needs.

1.2. Before carrying out a non-insured procedure for the first time, physicians must ensure they have sought and obtained CPSS approval for the appropriate scope of practice in accordance with CPSS policy "Scope of Practice Change". The current CPSS standards document for *Change in Scope of Practice for Medical Aesthetics* is attached as Appendix A.

1.3. In addition to obtaining approval for scope of practice, physicians must ensure they can safely perform the procedure, by undergoing training or seeking opportunities for supervised practice.

1.4. Physicians must take part in activities to maintain and develop their competence and performance across the full range of their practice.

1.5. Physicians are expected to practise evidence-based medicine, and to maintain a level of understanding of the available evidence supporting the procedure as it evolves.

2. Safety and quality of care

2.1. Physicians must be satisfied that the environment for practice is safe, suitably equipped and staffed and complies with any relevant regulatory requirements, including the CPSS guideline "Infection Prevention and Control Guidelines for Clinical Office Practice".

2.2. It is each physician's responsibility to take reasonable steps to ensure that a system is in place for the proper maintenance, cleaning and calibration of equipment used in the medical care they provide.

2.3. Physicians must be open and honest with patients in their care, or those close to them, and disclose if there is an adverse event. Physicians must be familiar and in compliance with the CPSS policy "Physician Disclosure of Adverse Events and Errors that Occur in the Course of Patient Care".

2.4. In the event of an adverse event, it is also the responsibility of the physician performing or authorizing the procedure to ensure a care plan is established to mitigate the effects of the adverse event in a satisfactory manner.

3. Seeking patients' consent

3.1. Physicians must be familiar and in compliance with the CPSS policy "Informed Consent and Determining Capacity to Consent", and the Canadian Medical Protective Association (CMPA) document "Consent: A guide for Canadian physicians" which has been accepted by the CPSS as an authoritative statement of the requirements for informed consent.

3.2. The physician who will be carrying out or supervising the procedure is responsible to discuss it with the patient and seek their consent. This responsibility must not be delegated or authorized to be performed by another medical practitioner unless the physician is confident the delegatee has the knowledge and experience to provide adequate explanations to the patient.

3.3. The physician must ensure patients have the information they want or need, including access to written information that supports continuity of care and includes relevant information about the medicines or devices used.

3.4. The physician must ensure the patient is provided sufficient time and information to permit them to make an informed decision.

3.5. The physician must consider the patient's psychological needs and whether referral to another experienced professional colleague is appropriate (i.e. body dysmorphic disorder).

3.6. The physician must take particular care when considering requests for procedures on minors or those with reduced capacity.

4. Authorization of non-physician providers

4.1. Physicians most responsible for care must assess the indications and potential contraindications for each patient. The physician must personally assess each patient undergoing an invasive procedure. The physician must be available to attend at the same location as the procedure is performed should circumstances arise where they are required to assist non-physician providers or to manage misadventure or complications arising from the procedure. "Available to attend" in this context means that:

4.1.1. A policy must be in place for emergent complications, including but not limited to anaphylaxis, allergic reaction or acute embolic event, and the authorized non-physician providers present must be appropriately trained to recognize emergent complications;

4.1.2. In the event of an urgent or semi-urgent complication, the physician most responsible for care must be available to attend within a reasonable time consistent with the nature of the complication.

4.2. If the physician most responsible for care is not available to attend as defined, there must be arrangements in place to ensure the availability of an equally competent physician to attend.

4.3. Physicians must ensure that anyone they authorize to participate in the patient's care has the necessary knowledge, skills, training and experience and is appropriately supervised.

4.4. Physicians must not authorize non-physician providers to perform any procedure unless the physicians are properly qualified to perform the procedure themselves.

4.5. Physicians must not authorize non-physician providers to perform any procedure that is considered the practice of medicine as defined in *The Medical Profession Act, 1981* unless delegation is specifically authorized in the regulatory bylaws or the person is a regulated health professional acting within the scope of their profession.

5. Obligations of medical director or physician performing, authorizing or supervising a procedure

5.1. If non-insured procedures are performed in a non-hospital treatment facility, the medical director of that facility is subject to the obligations enumerated in Bylaw 26.1.

5.2. If non-insured procedures are performed in a clinic, the physicians performing, authorizing or supervising the procedures are responsible to:

5.2.1. provide adequate and effective direction and supervision of authorized non-physician providers;

5.2.2. ensure that:

5.2.2.1. the procedures employed in the clinic are selected and performed in accordance with current accepted medical practice;

5.2.2.2. a procedures manual for the procedures performed is available and maintained for guidance of the medical staff;

5.2.2.3. the clinic complies with legal and ethical requirements for medical records, including access, confidentiality, retention and storage of medical records;

5.2.2.4. the clinic complies with the bylaws and ethical requirements with respect to the propriety and accuracy of advertising, promotion and other marketing activities for non-insured procedures provided in the clinic;

5.2.2.5. if procedures are performed at the clinic that carry a risk of cardiac arrest or allergic reaction, the physician must ensure the availability of appropriate resuscitation equipment and medications and the presence of staff who are appropriately trained to utilize said equipment and medications.

5.3. With respect to the performance of non-insured procedures, the physicians performing, authorizing or supervising the procedures shall ensure that the clinic does not:

5.3.1. establish criteria for referral of patients to the clinic other than those required by clinical considerations;

5.3.2. contravene the conflict of interest provisions of the College bylaws or guideline;

5.3.3. function to increase its profitability at the expense of sound medical practice;

5.3.4. allow unqualified or inadequately supervised personnel to perform any procedures.

6. Liability coverage

6.1. Any physician offering non-insured procedures or who is involved in authorizing non-physician providers to provide or assist in the same must ensure that the physician and other non-physician providers have appropriate professional liability protection.

7. Communicating information about services offered

7.1. When advertising office-based non-insured procedures, physicians must follow the applicable provisions in the Bylaws (Part 7) and Code of Ethics.

7.2. Physicians must ensure the information being published is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

7.3. Marketing in this context must be responsible. It must not minimise or trivialise the risks of procedures, or claim that procedures are risk free.

7.4. If patients will need to have a medical assessment or any additional investigations before a procedure can be performed, this must be made clear in the consent process.

7.5. Physicians must not mislead about the likely results of a procedure. They must not falsely claim or imply that certain results are guaranteed from a procedure.

8. Honesty in financial dealings

8.1. Physicians offering non-insured procedures must be open and honest with their patients about any financial or commercial interests that could be seen to affect the way they prescribe for, advise, treat, refer or commission services for patients.

8.2. Physicians must not allow their financial or commercial interests in a non-insured procedure, or an organization providing non-insured procedures, to affect their recommendations to patients or their adherence to expected good standards of care.

8.3. Physicians must be familiar with and in compliance with the CPSS guideline "Conflict of Interest" as well as Bylaw 9.1.

9. General requirements

9.1. At all times, physicians must maintain full direction and control of their medical practices, including:

9.1.1. the medical care provided to or for a patient;

9.1.2. the safety and quality of the premises in which they practise and of the equipment and the supplies used, including proper maintenance, cleaning and calibration of equipment used in the medical care they provide;

9.1.3. the qualification and performance of each staff member supervised by the physician.

ACKNOWLEDGEMENTS

The information in this document is based upon the following:

UK General Medical Council - *Guidance for doctors who offer cosmetic interventions*

CPSM - Bylaw 11 *Standards of Practice of Medicine*

Change in Scope of Practice for Medical Aesthetics

Applicants are responsible for submitting the required documentation to the College of Physicians and Surgeons to evaluate skills and qualifications for scope of practice change requests related to aesthetic and cosmetic medicine.

Required Qualifications

1. Use of Neuromodulators (Injectable)

- Evidence of didactic training in facial muscle anatomy and the basic science of neuromodulators.
- Completion of 16 documented hours in sessions focusing on the use of neuromodulators.
- Performance of at least 3 neuromodulator injections under direct supervision.

These are the basic requirements to incorporate the practice of cosmetic injections of the face only.

Documentation of additional training and experience may be required to use Botox™ for medical purposes such as hyperhidrosis, migraine therapy, bruxism and TMJ.

2. Soft Tissue Augmentation (Injection of Dermal Fillers)

- Evidence of didactic training in facial anatomy and the basic science of soft tissue augmentation.
- Sixteen (16) documented hours in sessions focusing on the use of soft tissue fillers. (These hours can overlap with anatomy and basic science of neuromodulators)
- Performance of at least 5 soft tissue augmentation injections under direct supervision

3. Light and Laser Based Technologies (To Maintain/Improve Skin Health/Skin Tightening/Body Contouring/Tattoo Removal/Hair Removal)

- Evidence of didactic teaching in the basic science of light/laser technologies and the interaction between light/laser energy and the skin.
- Sixteen (16) documented hours attending sessions focusing on the basics of light/laser technology.
- Documented evidence of training on the device(s) that the practitioner will be using.
- Three (3) documented completed cases on the device(s) the practitioner will be using.

4. Hair Transplantation

- Documented evidence of didactic teaching in the anatomy/histology and physiology of hair and scalp, the physiology and pharmacology of local tumescent anesthesia, safety and complications, and discussion of surgical technique.

- Twenty-four (24) accredited and documented hours in the basic principles of hair transplantation.
- Completion and documentation of an accredited hands on course in hair transplantation.
- Current Basic Cardiac Life Support (BCLS) certification.
- Three (3) documented cases of hair transplantation completed by the practitioner.

5. Invasive Body Contouring (Liposuction) Using Tumescent Technique, Powered, Ultrasonic, Laser, Radio-Frequency, Water Jet, or Equivalent Technologies

- Documented evidence of didactic teaching in the anatomy/histology and physiology of adipose tissue, the physiology and pharmacology of local tumescent anesthesia, the physiology and pharmacology of fat removal, safety and complications, and discussion of surgical technique.
- Twenty-four (24) accredited and documented hours in the basic principles of invasive body contouring.
- Completion and documentation of an accredited hands-on course in invasive body contouring.
- Current Advanced Cardiac Life Support (ACLS) certification.
- Documented training on the invasive body contouring device(s) the practitioner will be using.
- Three (3) documented cases completed on the device(s) the practitioner will be using.
- Additional facility approval and accreditation may be required, depending on the setting in which the service will be provided.

6. Evidence of appropriate training and experience will be reviewed on a case by case basis for additional procedures such as:

- Sclerotherapy
- Injection of platelet rich plasma (PRP)
- Injection of mesotherapy agents
- Other invasive aesthetic or cosmetic procedures

These qualifications are based on standards in other jurisdictions as well as training/certification programs available for physicians. Some didactic components may be combined when basic science and anatomy are related.

These requirements may be updated as the practice of aesthetic medicine changes.

Stakeholders

Thank you for providing the Canadian Medical Protective Association (CMPA) the opportunity to participate in the consultations on the College's draft Standard of Practice on Performing Office Based Procedures.
As you know, the CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medico-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 100,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medico-legal issues.
The CMPA welcomes the College's initiative to develop this new Standard and is pleased to offer the following comments.

Liability Protection
Adequate Liability Protection
The CMPA recommends that the draft Standard on Performing Office-Based Procedures emphasize the importance of ensuring that all regulated and unregulated health professionals working with supervising physicians have their own independent and adequate liability protection. It would be helpful if physicians were encouraged to consider whether the liability protection of all members of their health care team is adequate and commensurate with the risks posed by their involvement in patient care. The CMPA wishes to highlight the importance of adequate liability protection for all health care team members, given the reality in the health care sector of collaborative practices. Such CMPA_CA\ 39807815\1 Dr. Anna Ziomek 2 July 12, 2021 protection is also essential to better protect patients by ensuring they receive appropriate compensation in the event of negligence.

Terminology

The CMPA requests a minor change to the insurance language used in the title of section 6 of the draft Standard named "Liability Coverage". It would be preferable if the term "Liability Protection" were used instead of "Liability Coverage" to accurately reflect the nature of the CMPA's assistance.
You are likely aware that the CMPA is a mutual defence organization and not an insurance company. As such, the CMPA prefers to avoid, where possible, the use of any language that could be construed as suggesting it is an insurer.

Application of the Standard
The College may want to clarify whether the draft Standard applies to procedures performed in Accredited Facilities as well as procedures performed in Medical Clinics.

Several sections of the draft Standard indicate that it applies to Medical Clinics, however, the "Application" section of the draft Standard indicates that it applies to procedures performed in a facility accredited under the Accredited Facilities Bylaw.

It may be helpful to specify in the definition of "Medical Clinic" whether an Accredited Facility would also constitute a "Medical Clinic" for the purpose of the Standard and whether the requirements in the Standard apply differently to Medical Clinics as compared to Accredited Facilities.

For example, paragraph 4.1 under the section related to delegation to non-CPSM members requires that the most responsible physician be identified for every procedure performed in a Medical Clinic, while paragraph 4.4 speaks to delegation to non-CPSM members who perform a procedure in an Accredited Facility. It may be unclear to physicians whether there is a distinction in their obligations depending on the setting in which they practice.

Delegation
It would be preferable if the draft Standard provided additional guidance regarding delegation of reserved acts to non-CPSM members.

Section 4 of the draft Standard states that members may delegate to non-CPSM members the performance of any procedure. However, paragraph 5 of Appendix 1 (Injection of Fillers) indicates that it is not acceptable to permit anyone other than a regulated health professional (acting within their scope of practice) to perform injection of fillers. It would be helpful if the draft Standard was amended to ensure consistency between these two sections. It may also be helpful to provide additional guidance or examples of the types of delegation that would be appropriate for both regulated and unregulated professionals.

We hope these comments will be helpful to the College in finalizing the draft Standard on Performing Office-Based Procedures.

I am responding to your consultation on behalf of the College of Physiotherapists of Manitoba.

Since no standard currently exists for these types of procedures, I applaud your work on developing the standard to cover these important topic. The contextual information document section about "Relevant and Significant Training" was of particular interest as our College also grapples with this topic for any type of procedures learned after basic physiotherapy education. I would agree with the position you have taken for its simplicity. The section on LASER safety is also relevant to the physiotherapy profession.

The Delegation section is also of interest as it can apply to physiotherapists although most often it is a nursing interest.

I do not have any suggestions to make but recognize and congratulate you on the good work you have produced.

The following is the feedback from Manitoba and Seniors Care in relation to the Standard of Practice for Office-Based Procedures

- There is a typo in the first line of the third paragraph under ``Relevant and Significant Training`` - ``can not``
- Re delegation – It may be beneficial to note as an example in second introductory paragraph that *registered nurses are not permitted to accept delegations.*
- With respect to the sections respecting making a decision to delegate and engaging in the process of delegation, the stem should refer to what members ``*must*`` do pursuant to section 5.15 of the College of Physicians and Surgeons of Manitoba General Regulation (the ``General Regulation``). The use of the term ``should`` in this context suggests that this is not mandatory. In this regard, it may be beneficial to note what the requirements of section 5.15 of the General Regulation are.
- It may also be beneficial to note in this standard the reserved acts that cannot be delegated pursuant to the General Regulation.

Regarding SoP Office Based Procedures 4.1 & 4.2

1) PA/Cl.A are members of CPSM. I read this section as indicating Associate members as being able to supervise non-members in some procedures.

2) I feel that this paragraph does not identify the PA as the primary and my personal interpretation is that it can be anyone delegated by the physician and the physician should personally examine the patient receiving the invasive procedure.

3) I feel this article will place an unnecessary burden on one clinician rather than allowing individuals to assess their own skills.

4) "Delegate" is not included in the standards definitions. There needs to be a clear definition for delegate or perhaps "delegate member".

5) I would prefer to see Associate Members or Physician & Clinical Assistants specifically mentioned. Additionally, the term delegate implies that the task or procedure has been delegated which specifically excludes PAs/CAs and nurses as Physicians cannot legally delegate to other CPSM Regulated Health professionals as per the RHPA

6) This is a slippery slope; if we only allow those with most experience to be the ones performing the task, how will anyone develop?

7) Does this mean I can't do a simple excision without the patient being personally assessed by a doctor? that seems unreasonable.

Regarding SoP Office Based Procedures 4.4

1) I believe it is clear.

2) It does not have a clear identifying factor for the non-physician provider. But it does not affect my practice for my current set up.

3) I think it equates "member" with physician and ignores PAs and our ability to delegate if needed.

4) The definition of member is "a member or associate member of CPSM". Therefore, interpretation of this SoP from PA perspective tells me that PAs can delegate office procedures to a medical or PA student for example. I think this is clear.

5) This article is restricting non-CPSM members. I foresee concern about who which non-CPSM members this applies to since the CRNM has concluded their members can not receive delegation from Physicians. The RHPA restricts delegation to outside their membership which includes PAs and CLAs which seems appropriate as they are supervised and not delegated to. 6) What constitutes "supervision"? Is it direct or indirect? If direct, then I may as well not be adding much value to my MDs practice

To provide CPSM with additional insight into the Manitoba PAs role in Virtual Medicine, we asked our members to comment on the following question: "Is there any other feedback you have for the CPSM regarding these three SoP updates?"

1) Thank you for this opportunity

2) I am happy that CPSM is updating the SoP and I would love this format of review more often. Thank you.

3) Physician Assistants play a vital role in the Manitoba healthcare system. They have a significant impact on the health and wellness of our society and improve access to medical care in institutional and non-institutional settings throughout Manitoba. CPSM should consider specifically mentioning these associate members, whenever possible, in the standards of practice to help define how the PA/MD relationship should be evolving to protect the public as further implementation of these interdisciplinary teams continues.

Thank you for the opportunity to review and provide feedback on the Standard of practice for performing office based procedures

CRNM has been involved deeply in discussion with the formation of this document through our Quality Practice team. We have do not have any feedback on the document and would like to express our appreciation for inclusion in the working group.

On behalf of CPSA, thank you for allowing us the opportunity to review the draft *Performing Office-Based Procedures…* standard of practice and provide feedback.

Again, the standard and appendices are very clear: we encounter numerous queries that are very well explained in this document.

CPSM may wish to consider the following:
1.3 Is there a specific frequency/time frame for competency (e.g., annually)?
2.1 This is a great way to address things like “Botox parties.”
2.5 Is there responsibility on the part of the member to notify CPSM of harm as well, or just the Medical Director (e.g., in the
event the Medical Director is not aware of the harm)?
2.6 Since 2.4 discusses the requirement to disclose harm, it may be helpful for the definition and examples of harm to be
clause 2.5 (i.e., swap clauses 2.5 and 2.6).

3. Is obtaining informed consent something that can be delegated?

5. Are there obligations for non-Medical Director members (e.g., responsibilities for their individual practice that cannot be
Delegated to a Medical Director)?

5.4 Extremely clear – excellent.

If you have any other questions or require additional information, please let me know how I may be of assistance.

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VIA EMAIL

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

obp@cpsm.mb.ca

Dear Dr. Ziomek:

Doctors Manitoba appreciates the opportunity to comment on the proposed Standard for Office-Based Procedures.

The CPSM's willingness to strike a Working Group to engage members across numerous areas of practice, as well as the College of Registered Nurses of Manitoba, who are familiar with conducting certain procedures in offices or medical clinics has resulted in a proposed Standard which is largely satisfactory.

We will limit our comments to one area of the proposed Standard.

Male Circumcision

Doctors Manitoba has concerns about the provisions of the proposed Standard which would prevent physicians from performing male circumcisions outside of a medical clinic. There should be a limited exception granted for male circumcisions performed in the course of a religious ceremony or tradition.

Only a small number of our members perform male circumcisions outside of medical clinics for religious reasons. However, this is a matter of great importance for a substantial number of our members and Manitoba families, for whom the procedure is a fundamental part of their Jewish faith.

We believe the issue is easily resolved by a simple amendment mirroring the wording in Section 4 of the General Regulation under *The Registered Health Care Professions Act*, which we will set out below.

We are aware that CPSM has received other submissions on this issue, and this matter has been raised in the media. We will focus on why the proposed Standard as presently worded would not enhance patient safety and, if anything, reduce patient safety in Manitoba.

What is the Standard intended to address?

We have reviewed the consultation document. We note the CPSM has provided the following three justifications for creating the new Standard:

1. Members contacting CPSM and seeking clarification on requirements before entering a new scope of practice or business enterprise;

2. Members have entered into a new scope of this type of practice or business arrangement without forethought into what requirements there may be; or
3. CPSM has received complaints related to these types of procedures, which have led to disciplinary actions, criticism, or advice from the Investigations Committee.

Generally, we agree that the other procedures set out in the Standard may result in one of more of the above concerns for the CPSM. However, we do not believe that male circumcision outside of a medical clinic for religious purposes has created any of these concerns. We are not aware of the last time (if ever) CPSM has received a complaint respecting male circumcision outside of a medical clinic.

We understand from our members that the circumcision ritual generally takes place at a synagogue, the home of the parents or other family, or occasionally at a hotel or community facility. Restricting members from performing the procedure outside of a medical clinic would prevent physicians from being part of a religious tradition.

We understand that CMPA provides coverage to our members for performing male circumcisions in the course of a religious ceremony outside of a medical clinic.

What will happen if the Standard is adopted in its current form?

We believe that if the standard is adopted as written, there will be unintended consequences which will impair rather than support patient safety.

We anticipate that families who wish to proceed with the ritual for religious reasons will do so, whether or not it can be performed by a physician. We understand this would mean a rabbi, or even a layperson, would perform the procedure instead of a physician who is properly trained and answerable to the CPSM, and insured through CMPA.

Surely this cannot be what the CPSM intended.

We are not aware of any similar provision imposed by other Canadian regulators.

We have not conducted a full analysis of the human rights implications of the Standard, although we have reviewed certain other submissions, including the submission of Professor Bryan Schwartz of the Faculty of Law at the University of Manitoba. We do have concerns that this Standard could be challenged by a member or a Manitoba family by way of a claim under the Charter of Rights and Freedoms (as the CPSM's role is a regulator is granted by statute), and/or a complaint under the Manitoba Human Rights Code.

What is the easiest resolution?

We believe a simple amendment to Section 1(b) of the proposed Standard of practice, by adding the words "in the course of a religious ceremony or tradition", would suffice. It is understood that all other male circumcisions must be performed in a clinic, hospital or facility. Of course, physicians performing male circumcisions outside of a medical clinic will continue to be bound by all of the Standards including the duty of care.

Thank you for the opportunity to comment on the Standard.

Sincerely,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

PUBLIC COMMENTS REGARDING CIRCUMCISIONS	
Total Comments Received: 272	Total standard letters received: 205

As per the details in the attached letter from the Jewish Federation of Winnipeg, I respectfully ask that the College of Physicians and Surgeons of Manitoba exempt male circumcision from the Standard of Practice. This is a religious ritual which throughout history traditionally takes place in the home of the new parents or in the synagogue. We are fortunate in the Jewish community to have two physicians who have been properly trained to perform ritual circumcision.
Thank you,

I have read that the Manitoba College of Physicians and Surgeons is proposing to prevent doctors from performing Jewish ritual circumcision, brit milah, in homes and synagogues.

I think that the proposed change to the Standard of Practice is an attempt to fix a problem that does not exist. I hope that the College will comply with its obligations under the Charter of Rights and Freedoms and rescind the proposed Standard of Practice, or amend it to exclude ritual male circumcisions.

I write to draw your attention to one aspect of the above draft that is likely to create a furore in both the Moslem and Jewish communities – that of male circumcision. I address in this letter the Jewish ritual of *neonatal* circumcision, routinely performed, unless there are medical indications to the contrary, by a *mohel* (ritual circumciser) in the home of the new parents in the presence of family and friends. This ritual is arguably the most significant and ancient in the Jewish religion.

The Jewish procedure has been closely examined in the literature; in particular, there is a major Israeli study by Ben Chaim *et al*. and I commend it to your attention; a copy is attached. Quoting:

- *Non-medically trained* mohelim *perform the vast majority of circumcisions.*
- *In Israel, neonatal circumcision is commonly performed by a "*Mo- hel*" when the male infant is 8 days old; this ritual event usually takes place in a celebration hall in front of an audience of family and friends. The conditions are usually clean but not sterile, and anesthesia is not used.*
- *In 2001, of the 19,478 males born in four major medical centers in Israel 66 had circumcision-related complications.*
- *Complications of circumcision are rare in Israel and in most cases are mild and correctable. There appears to be no significant difference in the type of complications between medical and ritual circumcisions.*

In Winnipeg, Mathew Lazar MD, FRCPC, FAAP is a trained *mohel* who has performed many home or synagogue neonatal circumcisions in the Jewish community – indeed, he circumcised my own eight-day old son in our house – and I observed nothing that would lead me to question either his medical competence or the need for a sterile environment.

When one weighs, in the light of the above publication, the sterile (in both senses) setting of a medical clinic versus the joy of a highly significant and family-inclusive home religious ritual carried out with all due diligence, I cannot help but feel that home circumcision wins hands down.

In conclusion, I trust that you will correspondingly amend Item 2.1 of the proposed standard.

Dear College of Physicians and Surgeons of Manitoba, I am writing to you to ask that physicians not be restricted to performing male circumcisions only in authorized medical facilities. Such a rule would in my opinion add unnecessary stress and hardship for people trying to follow the laws of their faith.

Dear Doctors,
You must allow the continuation of Jewish ritual circumcisions to take place in synagogues and private homes.
This allows the Jewish people to fulfill and obey their Jewish traditions and obligations. There are no reasons you should ban this religious procedure.
Please confirm that you understand and accept the continuation of this practice. If for any reasons I'm not aware of, that you think this is a violation or if harm has been done in the past, please enlighten me.

I stand with Bnai Brith and their position that this infringes upon Jewish religious traditions and customs.
My son had his circumcision at 8 days post-partum at our local synagogue. It was performed by a Mohel (who actually is also an M.D. but my understanding is that they do not need to hold a medical license -however I sure felt better knowing it was someone with a medical background.) Please do not take away one of the first Jewish religious rituals in which a male child is part of.
The hospital setting is not appropriate for this milestone family event.

I would like to express my personal confusion at the justification for such a policy. Circumcision is an important Jewish ritual that is, for many Jews, core to our identity. Importantly, the bris is often an event of community gathering.

The proposal by the College is a ill-conceived limitation on Jews to practice the bris in the location of their choosing. Such a restrictions simultaneously curtails the freedoms of Jewish doctors to perform the role of mohel.

I am aware that circumcision is an increasingly controversial procedure. There is a belief among many that circumcision is a form of genital mutilation. That removing the foreskin has no medical or hygienic purpose, and that there is a resulting loss of sensitivity.

These concerns are not lost on Jews; however, the College is NOT the appropriate body to regulate religious practices of any religion, nor the engagement in religious activities by its members. I strongly urge the College to reject this proposal
By making it illegal, for Jewish ritual circumcision under supervised medical care outside of a medical facility, you will only drive this practice ,that has been performed for thousands of years, underground. Would you want a situation again, where abortions were done in back alleys with Hangers? This change will only harm and possibly cause death to some new born babies and represents an Anti-Semitic action that only the Nazis would enthusiastically support.
I respectfully object to the recommendation by the Standards of Practice Committee at the Manitoba College of Physicians and Surgeons to restrict ritual male circumcsions by physicians to a medical clinic facility . There is no reason that a Jewish bris cannot be performed in another environment such as a home by a licensed physician if the appropriate precautions ,equipment and medications are available to deal with any complications that might rarely ever occur.
I trust you have received many emails regarding the inclusion of male circumcisions amongst what would be considered cosmetic procedures. Please add my name to the list of individuals who are VERY concerned about this proposal.
I am deeply concerned by your proposal to limit male circumcision to medical clinics. Have there been medical problems with current practices? As a Christian I fully support the Jewish community in maintaining the centrally important traditions of the Brit Mila.
This item should be excused as I believe it would be a violation of my right to practice my religion
I am writing in regard to your current consultation about Office-Based Procedures with several questions: - why are male circumcisions being added to the list of office-based procedures—specifically what is the medical evidence for this decision - does this change apply to both eight-day old infants and adults - why did the College fail to reach-out to a stakeholder group, the Jewish community, that would be adversely impacted by this change - do the College's decisions supersede the Canadian Charter of Rights and Freedoms—specifically section two's Fundamental Freedoms of Conscious and Religion—which include the guaranteed freedom of expression "Under section 2 of the Charter, Canadians are free to follow the religion of their choice. In addition, they are guaranteed freedom of thought, belief and **expression** [emphasis added]." I await the favour of a prompt reply.

We are very opposed to the potential limiting physicians for doing the ceremonial circumcision if not in an institution. We have been doing this for thousands of years. Why now?
Please allow the Jewish ritual of a Brit Milah to continue in Manitoba.
The fact that a BAN has been declared is a violation of Human Rights and blatant ANTISEMITISM!!!! This is CANADA not NAZI GERMANY…… What is next a decree that only blonde hair and blue eyes are allowed! This MUST be overturned not only because it is a denial of human rights but because it denies the diversity,tradition and customs of all Jews and by the way Muslims as well of their religious values and traditions. Canada is made up of many diverse people that co-exist in peace and respect for mutual understanding. Instead of repairing the HATE of none is too many ,the death of Indigenous children,black lives matter and the list goes on Canada can not and must not accept any decree that is issued by the Christian White board that perpetuates the religious values of the rest of Canada! SHAME on the Board but shame on everybody else if they say and do nothing to reverse and stop this complicit attempt of denying basic human rights.
I was greatly disturbed to hear today of the College's proposal to ban male circumcisions, including for religious purposes, in any non-hospital setting.... which would constitute a significant and unjustified impingement on Jewish Manitobans' right to religious freedom, and would potentially spark a legal challenge. *This is contrary to important religious titusl and an unnecessary restriction. It also is contrary to our charter rights as jewish people* *I truly hope this is withdrawn and or I accepted* *Very ashamed that this has come forward*
Your attempt to ban male circumcisions outside of hospitals is clearly an attempt to deny Canadian Jews the ability to practice our religion. This is an attack against our religious rights and I would consider this to be an antisemitic attack against our fundamental rights. Do not proceed with this attack on our religion.
I was surprised and disturbed to hear today of the College's proposal to ban male circumcisions, including for religious purposes, in any non-hospital setting, which would

constitute a significant and unjustified impingement on Jewish Manitobans' right to religious freedom, and would potentially spark a legal challenge.
I have serious misgivings with the way in which this potential change has been rolled out. Despite the obvious and serious effect this would have on Manitoba's Jewish and Muslim communities, they were never consulted. This constitutes a serious breach of the College's duty to consult populations affected by its dictates, particularly religious minorities.
Specifically, any move to ban circumcisions outside of hospitals would have a significant and entirely negative impact on Jewish religious observance in Manitoba. For Jews, male circumcisions, typically performed on the eighth day after an infant's birth, are a critically important lifecycle event, rather than a mere medical procedure. Requiring all circumcisions to take place in a hospital materially interferes with Jewish religious observance.
The proposed Standard of Practice appears to be a draconian "solution" in search of a problem. I fully expect the College to comply with its obligations under the Charter of Rights and Freedoms and rescind the proposed Standard of Practice, or amend it to exclude ritual male circumcisions.

In our opinion it would be foolish and wrongheaded to ban or even limit circumcision for males in Canada as outlined in the proposal I just read for Manitoba.

The damage done to cultural continuity would be immense, and the loss of legal security would have a decaying effect on all religious practices thereafter. Just don't.

Naturally, we understand the difference between male and female circumcision, and they are intentions. We have not confused the two.

I was extremely disturbed to discover today of the Manitoba College of Physicians' new Standard of Practice would ban male circumcisions, including for religious purposes, in any non-hospital setting. This would create a significant and unjustified infringement on Jewish religious practice.
Brit milah, Jewish ritual circumcision, is done on the eighth day, or later if medically necessary, following the birth of a baby boy. Circumcisions performed earlier in the hospital do not fulfil the requirement. Mohalim are specially trained in ritual circumcision. In North America, more often than not, these individuals are also medical doctors who have sought this additional training and certification. There is no danger to a healthy baby boy to be circumcised in his home or synagogue under proper conditions, which are ensured by having doctors as mohalim. It is reasonable to expect that any doctor performing this procedure must work "within the limits of their competence and scope of practice." However, doctors who have trained as mohalim are doing exactly this, ensuring "they have the necessary knowledge, skill, and judgment to do so." Furthermore, this Standard of Practice would limit the Jewish community to mohalim who lack medical training. Given that there is no history of abuse or malpractice by doctors who serve the Jewish community as mohalim, this new SOP would create a danger where one currently does not exist.

Less than three years ago, Prime Minister Trudeau issued an apology for the "None is too many" policy, that the College would not only consider this change impinging on Jewish practice, but not consult or share this information with the Jewish community is particularly upsetting. This constitutes a serious breach of the College's duty to consult populations affected by its dictates, particularly religious minorities. I urge you to reconsider this addition to the proposed Standard of Practice, complying with your obligations under the Charter of Rights and Freedoms, and exclude ritual male circumcisions of babies.
I am very surprised and disturbed to hear today off the College's proposal to ban male circumcisions, including for religious purposes, in any non-hospital setting. This would be a significant and unjustified impingement on Jewish Manitobans' right to religious freedom. The Manitoba Jewish community would seriously be affected. Without consultation with the Manitoba Jewish community, the College has neglected it's duty to consult populations affected by it's dictates, particularly religious minorities. For Jews, male circumcisions, typically performed on the either day after an infant's birth, are a critically important lifecycle event, not a mere medical procedure. Requiring all circumcisions to take place in a hospital interferes with Jewish religious observances, is against the Charter of Rights and Freedom. Ritual male circumcisions needs to be excluded from the proposed changes to the Standard of Practice. I am shocked to hear of this discriminatory measure that you are taking. Male circumcision has been done safely in the Jewish religion for centuries. The only reason for forbidding it from being done outside of the hospital can only be antisemiitism.. So please reverse this decision of Jew hatred.
Such as preventing circumstances to not circumsize. It is a prevention against lichen sclerosis and health conditions. Why are you discriminating? Don't you dare pass this law. It would be harmful and stupid of doctors in Manitoba. Doctors are smarter than this. Not every doctor believes in this. We are in Canada a country of freedom. Aren't you glad you live in this country? Or you hate minority religious groups? Is that why? And you are not thinking about physicians' reasons? Think again.
As a senior Family Physician (over 45 years in practice) I find it abhorrent to think that infant male circumcision , which is an obligatory act performed for religious reasons to millions of Jewish and Moslem boys should be restricted to being performed ONLY in a medical facility. These acts have been performed in synagogues, mosques and in people's homes for thousands of years with only the rarest of complications. I would hope that saner, and more compassionate, decisions prevail.
I was never aware how anti Semitic this country has become. On what basis is your government going to pass a law not allowing doctors to do circumcisions. We're now living in

the Middle Ages. Actually if possible, worse than the Middle Ages. I'm ashamed thst I live in this country
I would like to add my voice to those opposed to the proposed ban by the Manitoba College of Physicians and Surgeons has to prevent doctors from performing Jewish ritual circumcision, brit milah, in homes and synagogues. I believe that this goes against basic freedom of religion and basic religious practices. It would also cause an additional burden on the medical system.
I strongly oppose your plan to prevent ritual circumcision in synagogues and homes. As a Jew I feel this an ongoing assault on my religious practises. Please reconsider your proposal.
I am terribly disturbed to hear of the proposed ban on medical circumcision anywhere outside a hospital setting. Is making a hole for an earing next? There is no medical need for such a measure, which significant impinges on the religious rights of Jews and others. I strongly urge the College to reconsider this poorly thought out proposal.
I am writing to voice my opposition to the proposed change by The College of Physicians & Surgeons of Manitoba (CPSM),that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital. This is an extremely important and meaningful Jewish religious practice. The change would have a very negative impact on the community.
Did you know that a Jewish circumcision lasts a matter of seconds and is much less stressful than a hospital one? The baby is held not restrained and with one deft flick it's over. This proposal of banning Jewish circumcision is not only contravening the Charter of freedom to practice religion it has no doubt very little evidence if any that a Jewish circ causes harm to a baby more than hospital one. Please think with a big brain and an open mind and heart. It's an embarrassment really as this story is going viral globally.
This is very troubling... As a member of the Manitoba Jewish community I am troubled by the College to institute the proposed requirements. It smacks of Antisemitic, anti-jewish overtones. This is an age old religious requirement and the roll of the college should be to support its continuing unobstructed practice. I want to know **who the people are who suggested this new requirement**. It is important to know their names and I want to know who they are.
My 2 sons were circumcised at 8 days at home by a mohel who was also a Dr. My husband, my brother, my father, indeed almost every Jewish male born in MB was circumcised according to Jewish law in a safe at home ceremony. To suddenly ban Brit Milah with no legal or medical justification reeks of anti semitism. Shame on you!!! What's next? Yellow stars? Our community will not sit idly by and let you enact racist policies. I urge you to reconsider - listen to science, tradition, precedent and common sense.

Why is brit milah circumcision suddenly considered to violate CPSM values of what is acceptable and unacceptable? Even Hitler allowed Jews to practice their religious beliefs before gassing them. Rather ironic, isn't it?
I understand that the CPSM is considering restricting circumcisions by members of the CPSM to medical clinics and hospitals. I am a member of a Reform congregation in Toronto.(Holy Blossom) I have attended a few circumcision ceremonies at Holy Blossom. Each was conducted by a member of the CPSO in the sanctuary. While I have never enquired, I have never heard of any untoward results. Had something gone awry, I am fairly sure that I would have heard about it. In one case, I spoke with the doctor (a CPSO member) and saw his medical apparatus and sanitary precautions. I am a convert to Judaism. While I was already circumcised soon after birth, I did have to go through a further minor procedure. In my case, this was done by a well known and skilled surgeon in his office at the Hospital for Sick Children in Toronto. My point is that Holy Blossom sent me a list of people (mohelim) who do circumcisions in Toronto. All were physicians. My conclusion, which I urge upon the CPSM, is that physician circumcision, by a doctor trained and qualified to do the procedure outside a hospital or clinic , is safe. An alternative is for some Manitoba synagogues to become qualified as a “medical clinic”.
The new Manitoba legislation on Circumcision will have a serious effect on the religious practices of the Jewish Community. It will definitely impinge on the religious freedom guaranteed to all Canadians. Please have the legislation amended to allow a Jewish “Mohel” to continue his sacred duty as in the past. No serious problems have been encountered until now with the Jewish Mohel performing the circumcision.
I hope this email finds you well. I am writing to you today as a concerned Canadian. I have recently heard of a new Standard of Practice that the CPSM is considering to adopt. This standard would prevent a Jewish circumciser that is a CPSMm member from performing a religious circumcision in a synagogue, a tradition and Jewish law that is of great, sacred importance to Jewish people across Manitoba, and all around the world. It is most likely that this consequence of the new standard is one that is unintentional, as a highly regarded professional body such as the CPSM would never take on a standard that would oppose religious freedoms in Canada. I kindly ask that the CPSM reconsiders adopting this standard, and that the CPSM consults with the Jewish communities of Mantioba to better understand the extreme importance of this very common and sacred ritual. Thank you for your help in upholding religious freedoms in our province

People Brit Milah, comes about to all Jewish males after 8 days. This is a covenant handed down from the time of Abraham to my knowledge a covenant between Abraham, G-d and Jewish people There are people specifically trained to do this… and many are doctors …and when you mess with Brit Milah…you are also messing with a higher authority let that sink in
Your proposed new restriction has no REAL validity. How many 'bad' incidents have you encountered under the present system in the past 5 years in any part of Canada? "IF' you have any valid complaint, can it not be made safely effective to the organization(s) that govern present approved practitioners of BRIT MILAH ??
I'm writing to express concern at the inclusion of male circumcision in your proposed standard of practice change. Please consider removing the item: male circumcision from the list. The reason for the request is a plea for sensitivity. The restriction of location and practitioner for ritual male circumcision has the appearance of marginalizing a minority community. The Jewish community's traumatic experience of marginalization and persecution, often included legislation to disallow male circumcision. This was sometimes done under the cover of medical standards and sometimes under political and religious cover. Then repeatedly followed persecutions and expulsions. I believe that including male circumcision in the proposal causes more harm than the potential for harm male circumcision without this legislated standard of care carries. So, it would be callous to cause undue alarm and trauma to the Jewish community by including male circumcision in the proposal. Please don't give medical cover to those who wish to send the message that the Jewish community is not welcome in Alberta. Please don't participate, even inadvertently, in the acts of marginalization, attacks and loss of freedoms that lesser countries than Canada have encouraged in history and very recently.
For thousands of years this ritual has been a very big part of Jewish identity. To forbid this is a slap in the face of our religion. I beg you to reconsider this action, which is not "Canadian" in nature. Canada does not do this to its citizens. I urge you to reconsider your policy and to make the necessary changes to prevent this from happening.
These anti semitic changes you're thinking of making regarding circumcision are wrong!
Why is the College attempting to interfere in the lives of Jews in Manitoba? Butt out.

Banning circumcision by medical professionals has no scientific basis and will cause immense harm to many communities-why would you do this? Where is your evidence?
This proposed legislative change is merely a camouflaged attack on the Jewish faith In order to subvert the teachings and practices of our religious beliefs. Nowhere in Canada are such changes ,as are envisioned in this bill, been enacted. On behalf of myself and my family, I strongly implore you to desist from enacting this badly conceived bill.
There should be absolutely no restrictions/infringement on male Jewish circumcision To even consider doing this is an affront to being Jewish-please do not do this-it's abhorrent & wrong
Circumcisions have been traditionally carried out for thousands of years by those of the Jewish faith when there were no hospitals in existence. Any attempt to thwart the religious ceremony of doing this outside a hospital venue seems to be of no advantage to the public nor to the use of hospital facilities at a time when the facilities are required for real medical emergencies.
Stop this attack and the rites of a Jewish life, It is well anti religious and an attack on a Faith based fact as in our Religious belief. If you continue, Jewish people who birth Boys will go out of Province and list Manitoba a Province with a state of Bigotry against one of the Provinces main faith adherents.
Male circumcision performed by a “Mohel”, some of whom are medical doctors, has been a part Jewish religious tradition since time immemorial. Canada was founded on Judaea Christian values.
I don’t know why you suddenly decided to add restrictions on circumcisions in Manitoba but please understand that adding any restrictions on this age old religious Jewish requirement is an attack on the Jewish people and other faiths who might also have this requirement. Whether you intended to attack our faith and others or not, you have indeed done so! I urge you to back down from your proposed restrictions. Perhaps you should consult with Jewish organizations like B’nai Brith and others to hear our valid issues before you rush ahead with your proposals.
This makes no sense. “non-CPSM members can also perform ritual circumcisions and would not be bound by the proposed Standard of Practice” Why the double standard?
I was surprised and disturbed to hear today of the College's proposal to ban male circumcisions, including for religious purposes, in any non-hospital setting which would constitute a significant and unjustified impingement on Jewish Manitobans’ right to religious freedom, and would potentially spark a legal challenge. I have serious misgivings with the

way in which this potential change has been rolled out. Despite the obvious and serious effect this would on Manitoba's Jewish community, the community was never consulted. Any move to ban circumcisions outside of hospitals would have a significant and entirely negative impact on Jewish religious observance in Manitoba. For Jews, male circumcisions, typically performed on the eighth day after an infant's birth, are a critically important lifecycle event, rather than a mere medical procedure. Requiring all circumcisions to take place in a hospital materially interferes with Jewish religious observance. I fully expect the College to comply with its obligations under the Charter of Rights and Freedoms and rescind the proposed Standard of Practice or amend it to exclude ritual male circumcisions. Shame on you for not consulting the Jewish community. Brit Milah is a religious ritual which has been performed for thousands of years usually in a synagogue or the family home. The Brit Milah is a celebration shared by the family and community and could not be observed properly and may not be allowed in a hospital setting. Your province is the only area in Canada which places this unacceptable restriction on this observance. For the sake of the Jewish community, please reconsider and do not implement this unacceptable restriction which targets the Jewish community.
There is no valid medical reason to change the current practice of allowing Brit Milah – the ritual circumcision of Jewish boys – at homes or synagogues, as long as the procedure is performed by an authorized, trained professional. Please do NOT enact a new Standard of Practice that would bring in potential new restrictions on the critical Jewish ritual of male circumcision, or brit milah, members of The College of Physicians & Surgeons of Manitoba.
As an ex-Manitoban I view this as an infringement of the rights of Jewish residents of Manitoba. You may not have considered that it will be interpreted as a part of a campaign of anti-semitism that is sweeping Canada. There is now an official Federal task force investigating this outbreak of hate crimes aimed directly at Jews.
I am sending this email to you because of the "proposed " initiative to block the Jewish Brit Milah and bring it under CPSM jurisdiction. This goes against the Canadian Charter of Rights and Freedoms - 2a states Freedom of Conscience and Religion ; 2b states Freedom of thought,belief, opinion and expression et/el
I am writing today to voice my opposition to the proposed limitations on circumcisions which will have an adverse impact on Jewish ritual events. The proposed changes appear to beill-conceived and lacked the appropriate forethought.

It is distressing to hear that the CPSM has considered a decision that will have a significant and demoralizing impact on Jewish life in Manitoba. Perhaps there is an opportunity to reconsider this decision so that Jewish tradition which marks and celebrates the very beginning of our journey and is the essence of their covenant with G-D dating back thousands of years. Indeed, I have to believe this tradition must have been overlooked in your deliberations. This can and must be corrected.
As the grandmother of a baby boy whose brit milah (Circumcision) we had to watch over zoom during the pandemic, I am horrified that you are proposing to eliminate the ability to choose where to have such a special family ritual take place. A hospital is not a family gathering place where, post pandemic, large groups of friends and family could not be accommodated. While technically the ceremony could take place in our home, there is no mohel available to do it because in Manitoba he is also a doctor. Clearly, whether there was thought put into this proposal or not, the end result is anti-semitic. You need to re-think this immediately.
Please be advised that the ritual right of circumcision is a cornerstone of Jewish Ritual Law, practiced for over 3000 + years, since Abraham performed his own circumcision to honour his pledge to G-d, on behalf of future generations of Jews. The attempt by you to ban our ritual rights is discriminatory and breaks with Canada's commitment to religious freedoms. This is a direct infringement of our section 2A "right to freedom of religion" in a manner that far exceeds all reasonable limits. Please be advised that should you try and implement this discriminatory practice, we will be compelled to take you to court to protect our religious rights. You have been advised.
This ban would be an infringement upon our charter rights. Also some may deem it to be anti semetic.
Please reconsider this action. I, personally, (04/10/1934) am one of those Manitobans who had the experience without any evident detrimental effects.
I am a retired Jewish Ontarian lawyer with longtime professional and personal links to Manitoba. I'm disturbed to hear that CPSM is taking steps to prohibit registrants from performing circumcisions in the community.

Many providers of circumcision services in and to the Jewish community are physicians. This is as it should be.

Circumcision is an essentially risk-free cosmetic procedure when performed in a skilled manner, under sterile conditions, by skilled personnel. It has deep meaning in both the Jewish and Muslim traditions.

There is no rational or scientific basis of which I am aware for the CPSM to be "going there" in this regard.

Unwittingly, CPSM is seemingly joining forces or taking sides in an antisemitic (and Islamophobic) manner.

I earnestly call upon you to reconsider and refrain. Such a step brings CPSM into human rights and religious freedom disrepute.

A competent, licensed medical doctor, who performs circumcisions, should NOT be told where he may or may not do the procedure. If the infant is not healthy enough to have it done outside a medical clinic or hospital, that doctor can make such a decision on his own. In my lifetime, I have never witnessed a circumcision inside a medical clinic or hospital, but many at private homes and synagogues. Never knew of any problem arising. You seem to be looking for a solution to a non--existant problem, with untold disruption to Jewish community norms.

As both a lawyer and a practicing Jew I find the thought of the CPSM's infringement om this most important religious action both frightening and an affront to my position as a proud Canadian. As we interfere with fundamental aspects of culture that do not affect anyone outside that group we are transgressing the very human rights and freedoms that formed the basis for our just society. In these days of the discovery of transgressions that have occurred historically let us not move forward to create new ones.
As a child whose family fled Germany because of the holocaust I can only say that it is these small actions that can cumulatively lead to massive religious persecution and later disaster. After over 3000 years of ongoing circumcisions. Jews are happy and healthy because they have been spiritually enriched by the fulfillment of their covenant with G-d and they are physically blessed by an act that maintains cleanliness and health. Brit Milah is a celebration of the covenant with G-d and cannot be properly effected in a clinic or hospital. There are many pieces and they must all together confirm the agreement made between Abraham and G-d.
There is of course the question of whether this amendment offends the Charter and do we want to waste the money to make that determination?
In conclusion I respectfully request you withdraw this Standard of Practice.

I understand that the College of Physicians & Surgeons of Manitoba (CPSM), which regulates the medical profession in the province, is considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital.
If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of brit milah. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital.
I wish to speak up against attempts to restrict this fundamental Jewish religious and cultural practice.
While this may appear to be a minor change to some, it would threaten to fundamentally change the lives of many Manitoba residents. I am also concerned about a potential slippery slope toward more critical blows to Jewish life that I have seen in other Western countries.

As a Catholic concerned to not have medical professionals' rights to not participate in some medical practices transgressed by having them redefined as Standard of Practice, I am equally concerned that the Jewish community's human religious rights not be transgressed by redefining as Standard of Practice that ritual male circumcisions only take place in a medical facility.

When you consult with the Jewish community in Manitoba, you will find their practitioners eminently able to assist you in understanding and being reassured in this matter.

It has become known that you want to change the current method of Jewish people having a mohel or circumcizor performing a ritual circumcision in a place other than a hospital or such place. What are your reasons for this? How many children have died by having their circumcision at home with an authorized circumcizor or medical doctor who is also able to do ritual circumcisions in someone's home.
Toronto and Montreal, particularly, have many more Jewish boys born than in the whole of Manitoba and there has been no incidents of anything going wrong with the ritual procedure or it would have been publicized.

Why don't you, before making such decisions, speak to Rabbis and Jewish circumcizors in Manitoba and in Toronto or Montreal (which are much bigger than any city in Manitoba and have many more baby boys born there than in the whole of Manitoba) and see what they have to say.
Another thing, how will you handle the Muslim community if they object to their ritual circumcision being done anywhere other than in a medical facility and then Mr Trudeau and his henchmen will rise up and condemn you for Islamophobia. In the same way, I believe you are being anti-semitic by not allowing us to celebrate as we deem fit.
Why do you have to interfere when there is no reason to do so. What does this have to do with you if there are no cases of death or bad practice involved. Does your organization have nothing better to do with its time other than to harass the Jewish community?? What is

there that is bothering you about something you now nothing about and something which perhaps it would do you good to learn about before you pass judgment.
I support Brit Mila rel.igious ceremony to be performed privately
It's appalling to think that a religious tradition steeped in medical background and performed by a physician, is potentially banned from being performed in the comfort of a private home. This infringement of our religious freedoms and impacts all Jews in Manitoba.
I am writing to ask u to stop any ban on circumcision. "The CPSM does not appear to have considered the serious impact upon the Jewish community of this proposed change.
This is a fundamental Jewish tradition, and banning our Religious Rabbi from performing this procedure affects us a Jewish Race. It has been done for thousands of years, what has prompted this? Another attack on Jews!!
I have had a brother, born in UK, husband born in Czech Republic, 2 sons and 4 grandsons born in Ontario, all who had lovely family and traditional brit milahs at home. It is a great tradition and ritual that causes no harm either physically or psychologically. I STRONGLY urge you to leave this very important part of the Jewish tradition unaltered as it has existed for many centuries. It it should not be equated with female circumcision to which it bears no relation on any count
Circumcisions have, over many years, been performed safely, in homes, hospitals, and medical clinics. This is a minor surgical procedure accompanied by a religious service. In many situations nowadays, a medical person is asked to perform the circumcision. That is because people believe that the medical person has the knowledge of the procedure and the required need for asepsis. The procedure is usually done in a home to accomodate the older people of the family. If cpsm removes this safety feature from circumcision in the home, you will be doing a great diservice to the Jewish people of Manitoba. I am only aware of a single case in Manitoba where the circumcision was a medical disaster - and that occured in a hospital setting. The people involved did not understand the difference between a surgical Bovie and a hot-wire device. I am very aware of this because I was retained to investigate the Bovie.
As a hidden child Holocaust survivor who was circumcised after the war when he was four years old, I am very concerned about the proposed new CPSM rule wherein a member would only be allowed to perform a circumcision in a hospital or medical clinic. Those who would ban circumcisions out right will probably ask: By what logic should the proposed ruling be limited to doctors who have medical training, while non doctors would still be allowed to

perform circumcisions in a non medical setting? The logical answer to this question would seem to be to only allow such procedures to be done by qualified medical doctors in a medical setting. And eventually to outlaw the practice outright. This seemingly benign proposal should ring alarm bells over the proverbial iceberg looming beyond the Manitoba horizon. Our past history is a testament to our concerns.
I have read the online information/notification from Bnai Brith regarding the College considering implementing a ban on non hospital based circumcisions, and the potential impacts on the Winnipeg Jewish community's access to the best qualified person in the community to assure a doctor supervised performance of the ritual/procedure. I am unsure what has precipitated the new interest in banning the ritual taking place in the homes or places of worship of the community members, in the way it has beEn performed in the province for over a century, but cannot help but feel it is an undue and unnecessary restriction on the religious observance being performed safely by a qualified doctor, for observant families, in settings where they can share this meaningful observance with their family and loved ones, which is unlikely to be the case in the event that the ritual will need to take place in a hospital setting. I think that the proposed policy that will likely restrict the current community supported practice and practitioner is an unfortunate over reach and unwarranted restriction on the rights of a safe and very long standing religeous observance that may cause more harm than the continuation of the current safe process. Thank you for your careful reconsideration of the proposed policy change.
Boy - have you opened a hornet's nest with this circumcision issue. I'm being deluged with emails from various members of Jewish organizations who are in a high dudgeon over what the College is proposing. Is there any chance you're going to walk back what you're proposing? I have a deadline of Monday noon and I'll be writing about this story, but I'm hoping that the College will respond in some manner to concerns raised by members of the Jewish community before then.
I find it appalling that you would require circumcision in a hospital setting only. Our community has done it in synagogues and private setting for thousands of years.
To prevent this act of Jewish covanent would be a total violation of Jewish heritage. This ritual does its utmost to practice circumcission with utmost respect , love and safety bringing a new born before God. For thousands of years this practice has not damaged the body nor the psyche of Jewish males. There is absolutely no sound justification for its legal prevention.
I wish to express my concern about the potential new restrictions on the important Jewish ritual of brit milah. Since the main mohel in Manitoba is a CPSM member, it seems to me that

the impact of such a change would be very serious to the Jewish community; therefore I urge you to consider their needs and ensure that they are not infringed on.
Britt Milah Must not be banned for Health and Rituals sake.
While this may appear to be a minor change to some, it would threaten to fundamentally change the lives of many Manitoba residents. We are also concerned about a potential slippery slope toward more critical blows to Jewish life that we have seen in other Western countries. Please allow jewish families to continue this very important procedure that is a fundamental part of a jewish male's right of passage. It has been this way for thousands of years.
I think it's outrageous for the Manitoba collage to even think about making changes to CPSM. Since millions of Jewish men have undergone circumcisions for thousands of years, who do these doctors think they are to want to ban the practice? This is a case of religious freedom and they have no business interfering. It smacks of antisemitism.
I think this proposal is terrible. Circumcision is a fundamental Jewish practice and should not be made difficult to conduct with proposals such as the one that you are suggesting.
At a time when anti semitism is at an all time high in our country, it does not appear coincidental that your association is: "considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital." Do you feel the time to propose this change is ripe now given the prevailing negative feelings toward Jews? I find your proposal to ban traditional Jewish circumcisions another example of attempts to "white wash" or "gentile wash" away remaining Jewish traditions in our society.
To whom it may concern or to those who lack consideration when making decisions that impact religious practices: The text below is taken from your SOP. My comments are within highlighted in red: This Standard of Practice establishes the requirements for complicated office-based procedures. - Jewish ritual circumcision is NOT a complicated office-based procedure especially when done by a trained "Mohel" who in Jewish religion IS the trusted authority, even more so than an MD in a hospital or clinic where procedures as simple as this become complicated because of the environment and restrictions within. It has been developed for the purpose of patient safety. - Jews have yet in our existence to feel unsafe with a Mohel at hand whose sole purpose is to reinforce the covenant of Abraham and our trust in G-d. The following insured and non-insured procedures are governed by this Standard and any

CPSM registrant performing these procedures
must adhere to this Standard of Practice:
- Jewish ritual circumcision is NOT about insurance, has nothing to do with cashing in or finding fault within a medical faculty. I personally would feel worse having my son circumcised in a clinic / hospital vs G-d's house (a synagogue) or our own homes where we can worship and sanctify G-d properly outside of the secular politics that govern medical institutions that do not take into consideration the religious implications that are being impacted by placing limitations on where religious practices can be done.

a. Vasectomy;
b. Male circumcision;
c. Cosmetic/aesthetic procedures which may include, but are not limited to:
1. Application of laser energy and light-based therapies for the removal or ablation of skin lesions and pigmentation;
2. Soft tissue augmentation - injection of fillers;
3. Botulinum toxin/Neuromodulators - injectable
d. Procedures aimed at the treatment of known pathology may include, but are not limited to:
1. Peripheral stem cell injection as approved by Health Canada; and
2. Platelet rich plasma injection as approved by Health Canada;

- Look at the list above... who would go and do any of the procedures listed besides circumcision in a house or synagogue or place of worship?! The other procedures above are clearly not part of any religious practice so it would make sense to standardize where they are being done. I don't recall the last time I attended a "ritual peripheral stem cell injection" with family members at my synagogue.
The College of Physicians & Surgeons of Manitoba (CPSM), which regulates the medical profession in the province, is considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital.

- There are doctors and there are Mohels. The Rabbi who performed both my son's circumcision's was not a doctor. So the solution is simple. Mohel's perform circumcisions for Jews who want them to do it for them in a religious environment with friends and family and doctors who are CPSM members should stay out of the mix unless the circumcision in question is related to a medical condition in which case the right place to do it would be in a clinic or hospital as that would be considered a medical requirement.
The Need for a Standard
Currently, no Standard exists for these types of procedures which are growing in popularity.
- Jewish ritual circumcision is NOT growing in popularity. It has been going on in the exact same way for thousands of years! What has been growing in popularity is the botched circumcisions performed by doctors who don't realize that this is more a religious procedure than a medical procedure and needs to be treated as such, done in religious environment like in the home or a synagogue under G-d. You know what else

continues to grow in popularity? Antisemitism and the restrictions placed on Jews. Try to place restrictions on Muslims who practice Islam and it's all out war.
In general, these procedures are usually performed for non-medical purposes.
- If it's for a "non-medical purpose" then why standardize it?

My personal reflection on the actions of the CPSM:
If the "Standard" is enacted, this would constitute a significant infringement on the important Jewish lifecycle event of brit milah. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. This is just more red-tape liability bullshit and limitations on religious freedoms. No Jew sues a Mohel because of any liability when the circumcision is performed in a home or synagogue. We trust more in our religious leaders, Rabbis, Mohels and even Shochets (responsible for ritual slaughter for Koshering animals) because we know that their intent is to follow their G-dly responsibility to the letter. Hospitals and clinic doctors who don't have the same G-d fearing intent under the duress and pressures from their medical environment tend to be more quick in their acts with less intent to follow Jewish law vs getting the job done. This is not a job, this is a boy becoming a Jew under a biblical covenant thousands of years old and you want to limit that act in our lives to a cold, white-wall clinic or a hospital? Why not just strip us Jews of the ability to ENJOY and FEEL while you're at it!

The CPSM definitely does not appear to have considered the serious impact upon the Jewish community of this proposed change. You will only force us again like all other things to fight for our right to practice our religion and in doing so strengthen our unified goals as Jews. We will not have these attempts to restrict this fundamental Jewish religious and cultural practice taken away and as generations before, we will prevail. Remember, it is not us Jews who conduct violent demonstrations to be heard. We will bind together and use the means at our disposal, adhering to country law in order to expose the inequities or organizations who choose to act before they think.

There should be no restrictions . That is overstepping .

Circumcision of babies is a safe practice and there should be no restrictions on it which would limit traditional Jewish practice. I urge you to consult with the Jewish community before you consider any rules which would limit Jewish doctors from performing the procedure either in or outside of hospitals.

The College of Physicians & Surgeons of Manitoba (CPSM) should not consider a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital.

If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of brit milah. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. They have been done for centuries without any issues, so why the change now???? Seems like an opportunity to erase a tradition held by a minority groups in your province.

I have just learned of your well-meaning but ultimately misguided attempts to regulate the Jewish (and presumably Muslim) practice of ritual circumcision. Is there a crisis threatening the health of Jewish infants and Muslim teenagers that such guidance is needed? Is there a particularly pressing interest in regulating just this type of procedure? Or is this a solution looking for a problem?
I believe Canada has the same kind of church-state separation and protection of religious practices that we have here in the US. If I'm right, and if the wave of anti-Semitism that has unfortunately been sweeping over Canada has not corrupted the judiciary, it is hard to see how the proposed restrictions would hold up in court, especially absent any good reason for their enactment.
Jewish ritual circumcision has been around for about 4000 years now. In that time the Jewish community has survived hostile governments, inquisitions, holocausts, pogroms and attacks from all sides. We have held on to our traditions and they have served us well. We fully intend to continue to hold onto them, wherever we are and in the face of whatever opposition we may meet, and we will continue to survive and thrive.
For everyone's sake, I ask you to withdraw this decree forthwith.

I write in relation to the news that the College of Physicians and Surgeons of Manitoba is considering banning the ability of mohels who are also physicians from performing Jewish ritual circumcisions outside of a medical clinic.

A Brit Milah (Jewish ritual circumcision) is one of the essential tenets of the Jewish faith, taking place on the eighth day of life of a baby boy.
As a mother whose sons and grandsons were ritually circumcised I can unequivocally say that I would not have wanted to take my new baby out of my home, to a medical clinic full of potentially ill strangers, to await a circumcision absent the ability to celebrate with all the other rituals which are part of a Brit Milah.
The availability to have a mohel who is also a trained physician is a great benefit to parents and a source of comfort and security. The current mohel(s) who serve the Winnipeg community are indeed physicians and I am unaware of any non-physician mohel currently in practice in Winnipeg.
I cannot think of any reasonable rationale for permitting non-physician mohels to perform a Brit Milah outside of a medical clinic, while denying **trained physician** mohels the same ability.
I urge the College not to impose this new Practice Standard, which would serve only to negatively affect the health and safety of Jewish families and their newborn sons.

Why is the province considering to regulate circumcision?

The ancient Jewish ritual of male circumcision does not need new regulations to be put forth by the province! This religious ritual has been properly performed for more than 2000 years by Jewish expert circumcisers (*mohels*) in deserts, in forests, indoors and outdoors on the eighth day after birth without any problems all these many years. This proposed regulation would greatly infringe on this important Jewish lifecycle event that has been performed and celebrated by Jewish families all over the world for more than 2 millennium! So I ask you again, what is the purpose of banning circumcisions of Jewish male babies outside the hospitals/clinics setting?
I was circumcised 8 days after I was born by a practicing medical doctor in my local synagogue, surrounded by family and friends of family in line with thousands of years of Jewish tradition. I am fortunate to have been circumcised by a practising medical doctor and I am very appreciative of that. The same doctor, several years later, also performed a circumcision on my son. This time in another synagogue surrounded by family and friends. If the standards are changed so that a circumcision can only be performed in a medical clinic or hospital by a member of CPSM, that will mean that Manitobans will be forced to have someone other than a practising medical doctor perform this procedure in a synagogue or home. It will be a real loss if these services are restricted and who knows of the problems or issues that it could lead to. Having the circumcision service take place in a hospital or medical clinic is next to impossible. A quorum of ten is required, various services are performed and a festive meal is eaten afterwards. The logistical difficulties of arranging this, especially on the Sabbath or holy days are unresolvable. You must agree that it is certainly best if this procedure is performed by a practising medical professional and in that regard, I implore you not to restrict this access.
Our religious rights are being challenged. Please do not move forward with the change you are proposing. A doctors office or a clinic cannot safely or fairly be a location for a traditional circumcision with family and friends in attendance. I fear that this proposal is an attack on our Jewish community in Manitoba. No other Canadian jurisdictions have proposed changes. Why Manitoba? My grandchildren were safely circumcised by a Manitoba Physician in the home of their parents. It was a joyful event for our family as family and friends gathered to celebrate the safe induction of a new soul into our Jewish community. A Mohel is not as well trained and very few are even available in our times. My husband and I urge the college not to make changes in our province. This is an affront to our Human Rights as Jews living in Manitoba.
I don’t know why you suddenly decided to add restrictions on circumcisions

in Manitoba but please understand that adding any restrictions on this age old religious Jewish requirement is an attack on the Jewish people and other faiths who might also have this requirement. Whether you intended to attack our faith and others or not, you have indeed done so! I urge you to back down from your proposed restrictions. Perhaps you should consult with Jewish organizations like B'nai Brith and others to hear our valid issues before you rush ahead with your proposals.
Circumcision might have various health benefits, including:

Easier hygiene. Circumcision makes it simpler to wash the penis.
However, boys with uncircumcised penises can be taught to wash regularly beneath the foreskin.

Decreased risk of urinary tract infections. The risk of urinary tract infections in males is low, but these infections are more common in uncircumcised males. Severe infections early in life can lead to kidney problems later.

Decreased risk of sexually transmitted infections. Circumcised men might have a lower risk of certain sexually transmitted infections, including HIV.
Still, safe sexual practices remain essential.

Prevention of penile problems. Occasionally, the foreskin on an uncircumcised penis can be difficult or impossible to retract (phimosis).
This can lead to inflammation of the foreskin or head of the penis.

Decreased risk of penile cancer. Although cancer of the penis is rare, it's less common in circumcised men. In addition, cervical cancer is less common in the female sexual partners of circumcised men.

https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.mayoclinic.org%2Ftests-procedures%2Fcircumcision%2Fabout%2Fpac-20393550&data=04%7C01%7Cobp%40cpsm.mb.ca%7C7d39cba12e9846f145ee08d947c828b4%7C80dcc43e306749a8825db77b5caa9cca%7C1%7C0%7C637619747257284874%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=3Dy%2B0HRLRj1SxbdTglghK4Xgbn3xaSlTEXlKbu8UYzA%3D&reserved=0

The circumcision of Jesus is an event from the life of Jesus, according to the Gospel of Luke chapter 2, which states:

And when eight days were fulfilled to circumcise the child, his name was called Jesus, the name called by the angel before he was conceived in the womb.[1]

The eight days after his birth is traditionally observed January 1. This is in keeping with the Jewish law which holds that males should be circumcised eight days after birth during a Brit milah ceremony, at which they are also given their name.

https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fen.wikipedia.org%2Fwiki%2FCircumcision_of_Jesus&data=04%7C01%7Cobp%40cpsm.mb.ca%7C7d39cba12e9846f145ee08d947c828b4%7C80dcc43e306749a8825db77b5caa9cca%7C1%7C0%7C637619747257284874%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=XV%2Bh%2BR7AAkSFweCTa9oE31%2BuGp%2FpnwcTqcVJ3bM7EYE%3D&reserved=0

Nearly 23 million voluntary male medical circumcisions in Africa's HIV prevention drive

Twelve years ago, the World Health Organization (WHO) and the Joint UN Programme on HIV/AIDS (UNAIDS) recommended Voluntary Medical Male Circumcision as part of measures to prevent HIV infections. From 2008 to 2018, nearly 23 million men were circumcised and some 250 000 infections averted in 15 Eastern and Southern African countries.

https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.afro.who.int%2Fnews%2Fnearly-23-million-voluntary-male-medical-circumcisions-africas-hiv-prevention-drive&data=04%7C01%7Cobp%40cpsm.mb.ca%7C7d39cba12e9846f145ee08d947c828b4%7C80dcc43e306749a8825db77b5caa9cca%7C1%7C0%7C637619747257284874%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=FiLOqruiKN2ylsUYGzwY6N5io96pfGSgGRlJRMrUvt0%3D&reserved=0

I join with those who oppose this change to make circumcisions by physicians mandatory only in hospitals. Circumcision of males is an ancient commandment in the Hebrew Bible (Old Testament) and Jews have followed the practice for millennia as an essential ceremony of Jewish identity. The ceremony takes place mostly in the parents' homes or in a synagogue and the practitioner is normally a physician or trained mohel (circumciser). Medical safety is paramount but the prayers and ritual are also important.
I understand the CPSM has not consulted with the Jewish community leaders in Manitoba nor the professionals who carry out the ritual to understand the effect such a policy change will have on them. This is far more than a medical issue and such consultation is essential.
The proposed change has not been adopted or proposed in any other province by the medical regulatory body. Why in Manitoba alone? It smacks of either mindlessness or negligence or bad faith and maybe worse. Talk to those who are most affected and maybe consult with other provincial medical associations before taking action.
If you go ahead without doing so you are making a big mistake and will regret it.

PLEASE NEVER EVER DISCONTINUE THE SPECIAL BEAUTIFUL HUMANE RITUAL IN JUDAISM. THE BRIT MILAH STARTED BY ABRAHAM IS GENERIC AND INTRINSIC TO JUDAISM THANK YOU

I am alarmed by a proposed new Standard Practice that would prohibit CPSM members from performing circumcisions outside clinical settings; thus, effectively banning traditional Jewish ritual practice. They previously have been performed safely in conjunction with a celebratory

feast, holding religious significance, in Synagogues or private homes. Please, reconsider the proposed new Standard Practice.
It is wrong, outrageous and racial dismissive to not allow Mohels to perform male Brit Milah in a home, synagogue or private venue. This act is a recognition of the instruction by G-d for Abraham to preform a Brit Milah on his son and therefore separate a Jewish Man from all others. This act is celebrated by all family and close friends with a large meal, blessings, speeches and congratulations! You must re-reconsider this ritual that has continued for the past 1000"s of years. To prevent this moment of recognition is a complete disregard for Jewish laws and acts and represents prejudice and racism against Jews and this is against Federal Law. I strongly urge the CPSM to not implement this ruling and keep rituals alive through all religions, race and creeds. This CPSM recommendation is a slippery slope for all peoples ~ do not allow this to happen!
Your proposed restrictions on ritual circumcision will serve to further marginalize the Manitoba Jewish community, and make it much more difficult for young Jewish families to remain in the province. Please reconsider your proposal.
The Jewish lifecycle event of *brit milah* or ritual circumcision is typically a family event hosted in homes or synagogues, I understand that you wish to prevent physicians from performing them, which is contrary to the protection of the health and welfare of the public. I hope you will immediately announce that you will drop this odious idea, whatever your stated objective.
We would ,respectfully be opposed to the new change,regarding circumcision i.e.,only being allowed in the hospitals . We would like to see no changes -thereby, allowing doctors in the community, to practice a religious ceremony -Brit Mila is a religious and sanctioned right .
The ritual practice of Brit Milah for male Jewish babies has been practiced for thousands of years. It is unthinkable that at a time when the highest rate of anti-religious attacks are leveled against Jews in Canada that the CPSM would suddenly decide to outlaw Brit Milah. Unfortunately, Canada, which is one of the most beautiful democratic nations on Earth that celebrates freedom of religion has a growing anti-semitism problem. Brit Milah is a safe practice and frankly it is mandated by the Jewish religion. If you deny Canadian Jews the right to this practice you are denying them freedom of religion. It's that simple. The beauty of Canada is that it is a welcoming and fair minded country. At this difficult time, please don't make Canadian Jews who love and are loyal to their country feel that they must leave.
Circumcisions performed by a qualified mohel (often a paediatrician or other medical doctor, but not always) has been practiced for thousands of years. It is part of the covenant between Abraham and God, and passed down through the generations.

Done on the 8th day produces very little bleeding if any due to the baby's ability produce Vit K which isn't available before that date. Having worked in the Emergency room for 15 years in London Ontario, I can tell you that penile infections and the need for the foreskin to be removed on males as teenagers or adults is horrific, and sometimes requires surgery, with a very painful recovery. Plus there are studies showing less cervical cancers among the wives of circumcised men, less infections and if the dad has had it done, then their sons would look the same . Regular medical doctors should not be interfering with a religious practice that doesn't harm the baby. Not everyone can afford to come back for the procedure and certainly no new mother stays in hospital regularly for 8 days anymore. The trained Mohels not only knows how to do this, but are part of the community. Please retract your "new " rules and regulations. It is a small number of babies, yet very important to the Jewish families. Taking this away is taking away their rights as parents and might even be considered Anti-Semitic and under the "guise " of health.
This is a brit the Almighty made with Abraham and this is what differentiate us from other human beings. G'D forbid there should be a change or the celebration in the performance in this ritual whether in Canada or any other place in the world. Thank you for standing up
My husband and I have recently learned of the potential ban on circumcision by medical doctors in Manitoba. This is of great concern to myself and fellow members of the Canadian and global Jewish community given that this is a more than 5000 year old ritual based on our covenant with G-d. On the medical side, there are many negative implications of this policy if it were to be implemented. While circumcision is generally performed outside of the hospital whereby a trained mohel is hired to perform the procedure, the mohel is generally a trained physician which is critical for obvious reasons. As well, our 3rd son had a hyposoadious and required a urologist to perform the surgery at age 4 in a hospital setting. Research also shows numerous medical benefits of circumcision, such as a reduction in penile cancer. By implementing this restriction, less non-Jewish families may be interested in learning more about the benefits, which can potentially save their baby boy as he grows. My husband is a respected Canadian pediatrician and would be happy to speak further with your college.
Considering that this ancient tradition is basically quite safe, would it be reasonable for your group to review current practices and make recommendations that make it even safer?
As an active member of Canada's Jewish community, and as a former 30-year resident of Winnipeg, I am very concerned about your proposed change that would disallow your members from acting as a mohel outside of a medical facility.

Certainly, you will know that Jewish mohels are thoroughly trained and do not present any danger to infants. I urge you to reconsider. Could you please confirm receipt of this email and any change in policy that results from the concerns expressed to you by members of the Canadian Jewish community? Thank you very much. Be safe during this pandemic.
When my son was circumcised through traditional Jewish religious practice, it was one of the most moving ceremonies of my lifetime. Jews should be able to practice their religion without interference from outside sources. Stay within your bounds and stop interfering in Jewish lifecycle traditions.
As a Canadian and a Jew I strongly oppose any change to requirements of circumcision in Manitoba or elsewhere in Canada. We should launch a strong protest against any change to the requirements of how circumcision is to be done in the province of Manitoba. Freedom of religion practises would be impinged if it was required to only be done in hospitals or medical surroundings. I wish you much success in challenging any change and would be willing to sign a petition along with most other Jews in Canada.
I would like to express my view about your proposed changes to having male circumcision done only in a medical practice. I wholeheartedly disagree with this proposal. Please reconsider.
I have recently received a notice from B'nai Brith Canada concerning new regulations being considered by the CPSM to require the practice of circumcision to be performed in a medical clinic or hospital. While B'nai Brith sent me this notice in hopes I would use my voice to speak out against these possible new regulations, I am actually writing to commend you and I do hope that you succeed in this endeavour. While this barbaric practice should upset most people; to have it in a hospital would not only eleviate risks of potential medical issues, but it would give more justification to the Jewish community in continuing this practice, while seemingly immoral, in a safe and secure manner. Best of luck to you and your principles

Please stop the ban of CPSM members from performing circumcisions outside of a medical clinic or hospital. If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of *brit milah*.
A Brit at home is crucial to the continuing of our faith. The home ritual symbolizes to all present that the child will be brought up jewishly with high moral standards. Putting it in a hospital setting takes away our religious freedom
I support jewish circumcision the way it's done now and was done for over 3 thousand years. I oppose any restrictions on who and where it can be done.
Any attack on Jewish rituals and values is an attack under the Charter of Rights and Freedoms and will be disputed in the Highest Courts.
Kindly request that Jewish people in MB have an unalienable right to practice their long held tradition and practice of a Mohel performing male circumcisions .
It has been brought to my attention that Manitoba is considering a change in law that would make the brit milah process in Jewish homes (the male circumcision at 8 days of age) illegal. Please do not do this. The Canadian Charter of Rights and Freedoms protects freedom of religion, and this a one of the core facets of Judaism. Circumcisions are not merely the cutting of foreskin - they involve speeches, special foods, and community gatherings, - none of which could be performed in a hospital setting. I urge you to consider the religions that mandate circumcision and include us in your future discussions.
There should not be a law to prevent Jewish parents to have their male babies circumcised, according to their religion. It has been done from the beginning of the Jewish religion. It is performed by a person, termed a 'Mohel', who is experienced and specializes in this ritual of naming a male baby. The baby is soothed from the pain by placing a few drops of wine in his mouth. Because circumcision has some proven medical benefits, such as lowering infections of the penis, non-Jews often have their babies and also adults, circumcised. Some doctors in hospitals offer to do it. It is rare the baby has any side-effects.
The main *mohel*, or Jewish circumciser, in Manitoba is a CPSM member, and the mooted change would have the effect of preventing any future Manitoba *mohel* from performing

traditional Jewish circumcisions while maintaining a medical practice, which is standard across Canada. Please reconsider your Proposal.
I object to interference in Jewish Customs.
I strongly object to the proposed policy of the Manitoba College of Physicians & Surgeons, that will impose, without local or national consultation to Jewish communal representative organizations, a ban on male circumcision by a medical doctor unless performed in a medical clinic. The norm of the Jewish community is to have the *brit milah* ceremony in the home or synagogue, performed by a *mohel*, an expert on Jewish ritual circumcision, who today is most often a medical doctor. It is understood there have been no cases of malpractice in the Jewish community, in Manitoba or other provinces of Canada, on which to base this proposal. This is a poignant issue for me, particularly because my daughter is currently in her last week of pregnancy, expecting a son, our first grandchild. They are planning a ritual circumcision or *brit milah* for their son in the home. They will engage a *mohel* who is a medical doctor trained to practise circumcision. To explain the care involved in doing the *brit*, they are following covid-19 pandemic restrictions, and because this ceremony ritually needs to be observed inside, they will do so safely in the presence of ten adults within their family bubble. Unless the baby is not well enough to undergo the procedure, the circumcision will be done on the baby's eighth day. I think that the lack of consultation by the College of Physicians and Surgeons flies in the face of the Manitoba and Canadian Jewish community. It's potential consequences must be fully scoped out and understood by consulting with the recognized Jewish community representatives. My advice is that this Jewish ritual, when safely practised in the home or synagogue, should not be undermined, but instead be considered as a precious legacy.
We object in the strongest way possible to the sudden banning of male circumcision—a central and ancient ritual of Judaism, performed on the eighth day of a healthy infant's life—being done outside of a hospital. Has there been a sudden and unreported increase in harm resulting from this centuries-old practice? If not, this new legislation can only be viewed as anti-semitic. Kindly reconsider and do not include this religious practice in your new protocol.
I am writing this letter in support of the Jewish Federation and the Jewish community of Winnipeg to request that the College of Physicians and Surgeons of Manitoba not include the Jewish religious ritual of male circumcision outside of a medical clinic, but to continue to allow the performance of this ritual in homes and synagogues.
For Jews circumcision is identity. It goes back farther than the Star of David, farther than the menorah, the oldest of Jewish symbols. Forbidding Jewish doctors from involvement is an attack on our identity, an expulsion from the most enduring ethnic people in the world. Why now? when antisemitism is in resurgence? (I don't know how the proposal affects Islamic doctors, for they may be affected as well. But Islamaphobia also runs high).

I served on the working group re MAID. The college took the position that doctors who rejected any role, including refusing to direct patients to other doctors, would not be penalized. I recognize that requests for MAID are not the same as requests for a procedure on a newborn, but, in both cases, the proposed standard of practice would apply to the moral integrity of a physician, to their very identity. Individual identity and moral integrity are values higher than the scope of the College's standard setting.
As I'm sure you've heard, these standards of practice do not include the ability to perform male circumcisions outside of a hospital for religious reasons. I am not sure why this distinction is now made. If anything, a trained practitioner would be safer to perform an at-home circumcision compared with a non-physician. This of course relates to the Jewish practice of male circumcision for a newborn. It's embarrassing that it has come to this, but please make the acceptable changes to allow moyels (whether they be physician or not) to perform home circumcisions for religious practices. Don't make this a bigger deal than it has to be. Make the appropriate apology, and remove this stipulation. Otherwise it will become a national story, the CPSM will be embarrassed, and the change will inevitably happen, because it's absolutely insane to begin with. I trust the CPSM will make the right decision, sooner rather than later.
As you probably know circumcision is an important, and ancient, rite in the Jewish and Muslim religions. All the Jewish circumcisers are trained in this proceedure which has been continually practiced in Canada. I do not see why you would wish to ban these circumcisers.
I just learned of a new set of rules by the College of Physicians and Surgeons of Manitoba to ban the practice of male circumcisions outside of hospital settings for your members. Since this negatively impacts the practice of ritual circumcision according to Jewish practice, I urge that this rule be modified to include settings appropriate for the Jewish ritual, e.g., synagogues and residences. The almost universally observed practice among the Jewish people for eight day old babies should be made an exception. Trained and licenced mohels should be allowed to practice their skills, with due attention to the health and safety of the child, wherever it is deemed appropriate.
It was recently brought to our attention that the College of Physicians and Surgeons of Manitoba Draft Standard of Practice for Performing Office-Based Procedures (including cosmetic/aesthetic and minor surgical procedures, platelet-rich plasma therapy, and laser service) is in the public domain for consultation and feedback. Included in this Standard of Practice are male circumcisions. In point 2.1 of the draft, it is

noted “members must not perform, or cause, permit, or enable another person to perform any procedure in a location other than a medical clinic.”

The performance of male circumcision by members (physicians) has been included in the draft, however, the performance of male circumcision as part of a brit milah, or part of a Jewish religious ceremony, was not explicitly referenced.
You may or may not be aware that these circumcisions usually take place in the home of the parents of the boy child and thus would be illegal in your current draft. If brought into force, this draft as it is currently worded would therefore make the performance of a brit milah by a physician outside of a medical clinic a violation of the College’s Standard of Practice.
We would hope that you take this into account and add appropriate changes before you make this draft into law.

I am confused by the CFSM’s recently released proposed practise standard for conducting select procedures in medical clinics only. I don’t understand the logic in combining botox, fillers, laser procedures and other cosmetic/ aesthetic treatments with male circumcision without considering the implications for ritual circumcision?
First, and foremost, a Brit Milah (ritual Jewish male circumcision) is NOT a medical procedure. It is a Jewish religious obligation that confirms a Jewish male’s covenant with God, and it belongs in the sanctity of a Jewish home or synagogue NOT in a medical setting. Restricting the physician mohel (ritual circumciser) in where he can perform this religious commandment is deleterious for the baby, its parents, and the community. Aside from exposure to germs and the stress of having a private religious obligation performed in a public medical setting, the most experienced individuals in Manitoba capable of performing this obligation will not be available to families who wish to have a safe and religiously sanctified Brit Milah.
Winnipeg is a small Jewish community. A mohel who doesn’t perform circumcisions other than brit milah will not have the repetition and experience necessary to ensure a safe outcome.There are families in Manitoba who have the means to fly in a mohel from larger Jewish communities where there are larger number of Jewish baby boys, but many do not. Why would you restrict Jewish families' right to religious practise in a culturally appropriate venue - at home or at my synagogue - when the Provincial legislation explicitly permits it?
I am a committed Jew whose family has lived in Canada for 120 years as proud Jews. My grandparents, husband, son, nephews and cousins have all been welcomed into the Jewish community as sons of the covenant of Brit Milah. I am unaware of any problems arising in Manitoba over past generations that would preclude a physician mohel from performing a Brit Milah in a home or synagogue. It is unconscionable for you to create barriers that would restrict my future grandchildren from joining their religious community in a joyous event. Please reconsider point 2.1 and include the appropriate exemption for Jewish ritual circumcision in accordance with Federal and Provincial human rights legislation.

I hope you have already received many emails concerning the possible new Standard of Practice that would make members of your college unable to perform Jewish Ritual Circumcisions outside of a clinic or hospital. I do believe this new Standard of Practice was written with the well-being of

Manitobans in mind. However, the impact such a Standard would have on the Jewish community would be negative.

In our culture, it is customary to have a gathering at a private house or synagogue where the circumcision takes place. At this gathering, there will be praying, eating, blessings, speeches, as well as family traditions that might be observed. The act of the circumcision is important, though the events surrounding the circumcision have become as important as what the circumcision symbolizes. There is a community that is created or strengthened when welcoming the child into the covenant our people have with G-d. Furthermore, there is a connection between circumcision and the "giving" of the child's name, the latter of which occurs during the circumcision itself.

With this in mind, I ask the College to continue to allow its members to perform circumcisions at locations other than a clinic or hospital. Canadian Jews want their MOHELs (the people who do the circumcision) to be doctors, and we want to be able to continue to celebrate this religious duty the way we have for thousands of years, that being at home or in a synagogue surrounded by family and friends.

I am writing today to offer feedback regarding the draft standard of practice for office-based procedures. The College of Physicians and Surgeons of Manitoba must recognize and differentiate between male circumcisions carried out in the course of a religious ceremony or tradition, and those carried out for nonreligious purposes; and must exempt male circumcisions carried out in the course of a religious ceremony or tradition from the restrictions against performing this ceremony in a residence, hospitality facility, community center, temple, synagogue, or other house of worship. The justification put forth by the College for this restriction is to protect the citizens of Manitoba, specifically to prevent the theoretical risk of infections; but there has never yet been a documented problem, complaint, or infection in circumcisions performed outside of a medical clinic as compared to those performed in a medical clinic in Manitoba; nor is there any real world evidence of increased risk of infection in circumcisions performed outside of a medical clinic as compared to those performed in a medical clinic. Extensive studies have shown that midwives can safely manage a live birth in the home environment; this is of course much more complicated and higher risk than a fully trained doctor performing a simple newborn male circumcision in the home environment. Ironically by prohibiting trained physicians from carrying out this procedure safely, the college may be driving Manitobans to seek out less safe and more risky alternatives; and as shown by recent Covid-19 related experience, it is demonstrably safer and lower infectious risk to the newborn to have the procedure done in the home environment rather than being exposed to more infectious agents by coming to a clinic. If the College were to insist on restricting male circumcisions carried out in the course of a religious ceremony or tradition from taking place in a residence, hospitality facility, community center, temple, synagogue, or other house of worship, this would constitute a significant and

unjustified impingement on Manitobans' right to religious freedom, and would potentially spark a Human Rights challenge. The inevitable legal action would be fruitless, wasteful, expensive, and damaging to the reputation of doctors in general and the College in particular. At this time it is more than ever crucial for doctors to be seen as trustworthy sources of information and advice, rather than racist, intolerant, or hateful.

It was recently brought to my attention that your organization has prepared a draft policy on office-based procedures, which includes paragraph 2.1 that requires such procedures to be performed in a medical clinic.

It was also stated that you are considering public submissions received by July 16th. So here's mine:

Such a policy could prevent the Jewish rite of circumcision from being performed in homes, contrary to thousands of years of practice. Maybe it wasn't intended, but it is a likely consequence of such wording.

Given that there's no evidence that this traditional practice hasn't caused any significant risk through the years, I would submit there's no need to stop it.

Again, I recognize that this might not have been the intention of the policy drafters, but it could be the result.

Therefore, I would urge you to include a specific exception regarding circumcision in the final version of the policy.

Thank you for your attention.

Sadly I have just heard of your proposal to stop male circumcisions, I urge you to rethink this decision. For thousands of years this has been and will continue to be the first covenant of the Jewish people. To do this without knowledge and consultation with our Mohelim (Jewish people who ritually perform this scared task) is an unjustified impingement on Jewish Manitobans right to religious freedom locally and around the world.

Whatever the circumstances that has caused you to consider this erroneous plan, please look at it in the light of a Historical fact and the outcry it will cause around the world.

I read with concern the proposed change with regard to the location where doctors can perform a ritual circumcision for the Jewish faith, known as a brit milah.
I am confident that the proposal was envisioned to make the procedure safer for the child, and does not involve any bias against Judaism.
The effect could increase any danger associated with the circumcision. The person performing a circumcision in accordance to Jewish ritual is a mohel. The option to a doctor who serves the role of a mohel in a medical facility would be a mohel without medical

certification. While a mohel is competent to do the brit milah there is greater safety for the child if the procedure is done by a doctor, even if it is not in a medical facility. There would be an increase of circumcisions by non medically trained mohels. Please make the decision to not change the current regulations.
I grew up in New York. There was a time that new mothers and their babies remained in the hospital for a week or more. And Jewish hospitals had rooms in which eight day old boys could be circumcised, with guests present, and the customary congratulatory meal could be served. But, today, mother and baby frequently go home after a day or two and most boys are now circumcised at home or in synagogues. Often the person performing the circumcision is a medical doctor and the new rule requires CPSM-certified doctors to perform circumcisions only in hospitals or medical centers will impose a hardship on Jewish families seeking to have the traditional celebration in a home or synagogue setting. I ask you to reconsider the change in policy in light of its adverse effect on Jewish families.
Has any one of your members who are advocating this infringement on theJewish communities right to practice their religion under the Charter been considered? This is an infringement on Jewish tradition and religious law, which has been followed by Jews globally for thousands of years. Perhaps you may even be imposing restrictions on the Islamic faith and traditions. Will this infringement on perhaps the Muslim faith have greater sway in considering this ridiculous agenda of forcing people to have circumcisions done in the hospital if it affects more than the Jewish community? Hopefully your organization will come to its senses and do more meaningful work.
The decision recommendation regarding circumcision makes no sense if you are of the Jewish faith. I am confident that you will not proceed with this action Thanks for listening
Please add my voice to the above, All the best.
The discussion to ban a sacred religious ceremony is not one that I thought would be discussed by any Canadian group. As Canadians, we stand for rights and freedoms. Please do not allow this to happen. A concerned Canadian citizen.
Why in the world would you look to ban or place restrictions on this practice for the people of Jewish faith? Get your sh*t together and place attention on topics that matter.

I was surprised and dismayed to hear that your organization is contemplating implementing a policy that would fundamentally interfere and "criminalize" a thousands years old life ritual aspect of almost all Jewish families. It is hard to understand how this was not considered. Assuming that when the discussions relating to this proposed policy change took place there was an oversight, and we are all human, an exception can be carved out for Jewish ritual circumcision. If not, then a complex and unnecessary entanglement having to do with freedom of religion, human rights, and interference with the right to choose could very well ensue.
I would like to protest changes in the regulations governing male circumcision, especially for those of the Jewish Faith. While it has been medically proven that circumsion greatly reduces the incidence of disease to male genitals, the removal of the foreskin of a male child by a qualified practitioner in a home or prayer hall or hospital setting(parent's choice)is a ritual that has been been performed for 5000 years for those of the Hewish Faith, and for thousands of years by many other faiths. If it ain't broke, don't fix it.
Please reconsider CPSM's ill conceived, proposed position of attacking members for participating in the sacred Jewish ritual of the Brit Milah -Jewish Circumcision, outside of hospitals and medical clinics. This religious, cultural practice has safely taken place throughout millennia in the loving embrace and comfort of our synagogues and homes. Depriving Manitobans of the high standards a physician Mohel can provide in traditional settings is suspect and discriminatory. In these times of rising Global antisemitism, your leadership is signalling an attack on our sense of security, safety and freedom of religious practice and traditions. Perhaps this was unintended, but the harm is done. I strongly encourage you to abandon your short sighted ill conceived proposal.
The new restrictions on the critical Jewish ritual of male circumcision in Manitoba would have the effect of preventing any future Manitoba *mohel* from performing traditional Jewish circumcisions while maintaining a medical practice, which is standard across Canada. There is no evidence that the CPSM specifically consulted the Jewish community about the proposed change, despite its obvious impact on Jewish life in Manitoba. It is also not clear what prompted the proposed restrictions. There are no equivalent strictures on physicians in any other province.

I would just like to speak my mind that I am in favour of circumcision for all Jewish males and can't believe that you would ban this practice ! For many generations of males in my family this has been the practice and it would be devastating to all of us if this was not allowed!
I oppose the plan to ban physicians from performing circumcision outside of the hospital and clinic setting. This ban seems misguided and unlikely to result in better patient care in anyway. In addition, as this type of ban specifically targets Jews and other religious minorities, it only adds to the growing bigotry and anti-semitism we see in Canada. Why target Jews during a pandemic during which we have see countless acts of anti-semitism? Discard this ill advised plan and affirm the CPSM's commitment to fairness for all religious groups.
Traditionally Jewish circumcision is performed by a mohel. Some mohels are accredited physicians. There is no advantage to having circumcisions performed by physicians in a hospital while allowing non-CPSM members the right to continue performing the circumcision outside the hospital. Please review this policy so the CPSM members can continue to perform the ritual outside the hospital and afford the family and friends to attend this ritual
Please consider the rights of the Jewish community to circumcision by an md not in a clinic or hospital setting. It makes no sense that a non medical practitioner would be able to perform such circumcision but a Physician would not. Further I do not see the medical Reasons for the restrictions you are looking to impose
A highly important religious practise known as Brit Milah has been practised by Jews for over three thousand (3,000) years. Had there been a medical problem, with this highly important medical practise, then surely Jews would have ceased and desisted in their religious practises a long, long time ago. In the meantime, as with B'nai Mitzvot, weddings and funerals, it is not for your college to even consider terminating any one of four such very important Jewish lifestyle events. I can assure you that moving forward with such a restriction will only result in your college being involved in litigious disputes that you certainly cannot win.
Although I do not live in Manitoba, I would like to express my concern regarding a potential practice standard banning CPSM members from performing circumcisions outside of medical clinics/hospitals.

A standard like this will have significant implications on the Jewish community in Manitoba. Consultations should be made with the Jewish community living in Manitoba to assess the impact of adopting this care standard. I am curious as to what the reasoning is for a change like this at this point, considering no other province in Canada has this practice standard.
Please do NOT allow Manitoba to ban circumcision outside medical clinics!! This is outright targeting a Jewish male ritual of passage. My son many years ago, had a bris at the synagogue performed by a Jewish medical doctor and it should be allowed to stay this way in winnipeg! Family and friends were in attendance.
I read with great disappointment the desire of your organization to ban the Jewish ritual circumcision I appeal and urge you to reconsider your position on this issue, given that if your plan is implemented, it will have disastrous consequences for the Jewish community
I want to share my concern with an aspect of the College of Physicians and Surgeons of Manitoba's Draft Standard of Practice for Performing Office-Based Procedures (including cosmetic/aesthetic and minor surgical procedures, platelet-rich plasma therapy, and laser service), which is in the public domain for consultation and feedback. Included in this Standard of Practice are male circumcisions. In section 2.1 of the draft, it is noted *"members must not perform, or cause, permit, or enable another person to perform any procedure in a location other than a medical clinic."* The performance of male circumcision by members (physicians) has been included in the draft, however, the performance of male circumcision as part of a brit milah, or part of a religious ceremony, was not explicitly referenced. If brought into force, this draft as it is currently worded would therefore make the performance of a Jewish brit milah by a physician outside of a medical clinic a violation of the College's Standard of Practice. The brit milah has deep and fundamental roots in Jewish tradition and our heritage. Abraham was commanded by God to circumcise his son Isaac on the eighth day following birth. Since then, Jewish people have faithfully and continuously followed this commandment for thousands of years. A covenant between Jews and God, the brit milah is an indelible physical symbol of our everlasting bond with God. In addition, it is the rite of passage whereby our newborn sons are welcomed into the Jewish community, surrounded by the love of their family and friends. This ceremony is often performed in a synagogue or a family home. In addition, there is overwhelming evidence in peer-reviewed medical journals of the safety of circumcision and the skill of a trained and certified mohel (the person who performs the Jewish rite of circumcision). Please refer to the letter submitted by the Winnipeg Council of Rabbi's on July 14, 2021 which clearly states that Winnipeg doctors have been performing this for decades with no issues. The standard needs to be modified to make an exception if not indeed removed in its entirety. There is no reason that a doctor cannot perform a minor medical procedure in their clinic or office and to impose such a standard would needlessly increase costs to the Manitoba healthcare system for what purpose? This also greatly inconveniences those who would then have to travel to a hospital for such a procedure. Has

anyone thought about the wait times that already plague our healthcare system? The greater risk for infections in a hospital environment? There are ramifications beyond the infringement on religious freedom. I urge you to consider the implications of this standard, which would infringe on our right to religious freedom, and amend the proposed Standard of Practice to explicitly exclude Jewish ritual male circumcisions.
This is a practice that has taken place for over 2,000 years without incident. It happens in hospitals, homes, synagogues and elsewhere. It is a religious practice and not surprisingly has added health benefits. It would be totally wrong to prohibit this ceremony from taking place outside of a hospital. Hospitals and clinics are busy places, and cater to sick people. This is not the proper environment for a circumcision ceremony. Many of the people trained to do this one minor procedure are not medical personnel. They are much better and faster than most doctors because that is all they do and some do hundreds per year. I personally have witnessed the difference between a Rabbi doing it and a doctor and the Rabbi was faster, better and the child was happier. This is not an insult to doctors, my son is a doctor, it is just a fact. Please do not change the current practices in Manitoba.
I am outraged that CPSM wants to ban Jewish circumcisions outside of hospitals. The main criteria should be the health and safety of the baby. If this can be assured at another location, like a synagogue, then the practice should be allowed there. **I have just learned that The College of Physicians & Surgeons of Manitoba (CPSM), which regulates the medical profession in the province, is considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital.** **If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of *brit milah*. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches.** **This is very concerning to me and my family who are originally from Winnipeg. Please reconsider making this change.**
It seems to me that your organization is behaving in not only an anti semetic manner but showing unjust prejudice!! The folly of your organization is truly a joke! After more than 120 years of Jewish Brit Mila's taking place in homes in Manitoba(my sons, brother and probably my Father for instance), your attitude and " new thinking" reeks of prejudice!! Shame on the Manitoba Medical Association! Perhaps you will return to your quota on Jews accepted to U of M Medical School next!
I strongly oppose the Manitoba's College of P&S proposed prohibition by its members of circumcisions done outside hospitals. There seems to be no medical basis for this decision and it seems as if it is directed against the Jewish community. This procedure, called a brit milah, is a central ritual of the Jewish faith, for all denominations of Jews. It almost always

takes place in the home of the new born male baby and there is an important ritual around it involving the baby, the parents and grandparents, and the other friends and family of the parents. After the medical procedure, and a short educational talk by the mohel, who is a licensed medical doctor with great experience doing this ritual, there is an important breakfast social/religious gathering. I strongly oppose this proposed restriction and urge your College to rethink this restriction. You must consult with the leaders of the Manitoba Jewish community before this goes any further.
Keep the tradition, not the new stupidity.
Good evening College Of Physicians And Surgeons Of Manitoba. To circumcise a male according to Torah observance, is the cleanest way for a Male to live, to prevent diseases and infections. The washing process is very easy, as i am Torah observant, so please do reconsider you're treatment of Torah observant people. The Charter Of Rights and Freedoms guarantees Freedom Of Religion. Thank you for you're support in this matter.
I support the traditional Jewish ceremony of brith mila as it was performed safely for thousands of years without the intervention of outsiders that do not understand or care about the sanctity of the act.
I was shocked and dismayed after hearing that your society wants to stop members of CPSM from performing ritual circumcision in a home or synagogue! The circumcision of male jewish boys has been going on for centuries as dictated by God in the Bible. I am unaware of any circumcision in a home or synagogue that resulted in morbidity. Please reconsider your actions!!!!!
Manitoba could set an unfortunate precedent for other provinces with going pressure to ban brit milot. I think the reaction should focus, at least initially, on the absence of consultation with the Jewish Community and with Jewish medical colleagues. There is also need to set out the reasoning behind this decision. Another point is that Muslims are also affected by this decision. Were they consulted? And what is their reaction. Are they adopting a similar position as the Jewish Community?
I have become aware that you are considering banning CPSM members from performing circumcision outside of hospitals and and medical clinics. For over 3000 years, newborn Jewish baby boys have been circumcised on the 8th day. This is a commandment in the Torah, a book that is integral to Jewish life. Circumcising Jewish baby boys in their home is a family life cycle event where grandparents, relatives and friends are invited to join in the celebration of welcoming the baby into the Jewish faith. A meal is shared by everyone who is present. It's a time of congratulating the

family and wishing them and the baby good health. It is a time of spiritual and communal celebration.

Having a baby circumcised in an institutional setting not only takes away from the spirituality, warmth and connection people experience in a home setting, but also limits the number of people who can be present.

With all sincerity, I plead for your understanding the importance that this commandment be observed in the family home.

What you are attempting to do is not very "Canadian"!

We request your giving your every consideration to the following concern.

It has come to our attention that the College has drafted a Standard of Practice that is to be decided upon shortly. This draft includes a section that addresses standards for Male Circumcision.

We take exception to the following paragraph:

2.2. Members must only perform procedures in a medical clinic that is safe, appropriate, and sanitary, is suitably equipped and staffed, and complies with any relevant regulatory requirements, and the Infection Prevention and Control for Clinical Office Practice.

Please note that Male Circumcision is practiced as a Jewish Religious requirement, generally on the eighth day of birth, in either a synagogue or in the home of the family. The Mohel (person performing the circumcision) must be a practicing, religious Jew. He must be knowledgeable in the medical knowledge pertinent to the procedure, as well as being knowledgeable in the detailed and complex religious rules that govern the procedure of circumcision. Some religious circumcisers are also practicing physicians, while others, though not physicians, are highly trained specialists in their field that may have greater expertise in circumcision than ordinary physicians. In any case, religious circumcision is done under careful hygienic and safe practices.

The above clause would create a significant obstacle to the practice of the Jewish Religion in Manitoba, as the procedure usually cannot be done in a medical facility.

I fail to understand the point of this exercise. Brit Milah is a critical step in Judaism and your suggesting that non members could perform this but accredited medical professionals would be restricted when the community relies on such expert professionals for this duty smacks of subtle anti Semitic. It does not speak for the protection of some medical concern that does not exist.

I am writing this as a complaint against this decision. This has been an accepted and expected part of Jewdaism since the time of Moses ! To come in now and change the circumstances under which it is performed, would certainly be an act of racism ! I would strongly suggest that you reconsider any decision to change the method in which Jews have been performing circumcisions.
I am writing to protest any move to enforce circumcisions being done only in medical facilities. The current practice of allowing a mohel to perform the procedure in a non-clinical setting should not be interfered with. Interfering with a long-standing Jewish rite, that has been safely performed for a very long time, risks the appearance of anti-Semitism. No action should be taken by the College on this issue.
Please respect our covenant with god to circumcise our baby boys
Distressed that this decision is being made. Did not expect this in Canada. There are female circumcisions done in other cultures. What is the ruling on them?
I am writing to protest the plan by the CPSM to ban the practice of circumcision outside of a medical facility by a physician. Having safely performed around 800 ritual circumcisions for the Jewish community over 20 years in private homes, I can't fathom any justification for such a ban. This ban would accomplish nothing and would appear to be aimed at eliminating circumcision by those who oppose it. Ritual circumcision has been performed by far less qualified individuals such as rabbis and kosher butchers for thousands of years. The CPSM has no jurisdiction over these groups. The practice of ritual circumcision may again be practiced by rabbis and butchers if this restriction only affects physicians. Clearly this would not be in the best interests of the public.
We have had Brit Milah's or circumcision of all 4 of our boys, done traditionally at home or in our synagogue. We urge you to continue to allow this beautiful and meaningful commitment tradition to continue in homes and synagogues.
The proposed ban of CPSM members from performing circumcisions outside of a medical clinic or hospital will constitute a significant infringement on the important Jewish lifecycle event of *brit milah*. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. While I understand the CPSM has clarified that pursuant to Manitoba law, non-CPSM members can also perform ritual circumcisions and would not be bound by the proposed Standard of Practice; the main *mohel*, or Jewish circumciser, in Manitoba is a CPSM member, and the change would effectively prevent any future Manitoba *mohel* from performing

traditional Jewish circumcisions while maintaining a medical practice, which is standard across Canada. There is no evidence that the CPSM specifically consulted the Jewish community about the proposed change, despite its obvious impact on Jewish life in Manitoba. It is also not clear what prompted the proposed restrictions, and there do not appear to have equivalent strictures in any other province. I wonder what has driven the CPSM to consider such a ban - which incidentally would also affect the Muslim community in Manitoba. I would ask you to please reconsider this move, which would negatively impact the lives of thousands of Manitobans.
I am deeply troubled by the pending legislation that would prohibit any CPSM member from performing this vital Jewish ritual outside of a hospital. The ritual of Brit Milah is normally performed either at the home of the parents or at the synagogue. It is one of the most important ceremonies of the Jewish religion and this restriction would be a huge blow.
The potential new rule where doctors can only perform a circumcision in a hospital or clinic is self-limiting and of no benefit to anyone. It would be like saying a doctor cannot treat a patient out of a medical setting. The current conditions have been safe and there's no need to change them. In fact changing them, may in fact cause problems instead.
With all due respect, it defies logic that the CPSM should prevent doctors from performing circumcision on Jewish infants outside a clinic. They have been doing this for years with no ill effects. In fact, if there is a problem the doctor would recognize the problem and postpone the circumcision, and not put the child at risk. Put your efforts in the so many places that really need attention and the people of Manitoba will be grateful.
I was born and grew up in Winnipeg and still return most Summers to go to our family cottage in the Whiteshell. I read today that the CPSM is considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital. If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of *brit milah*. *Brit Milah*. According to the Book of Genesis, God told Abraham to circumcise himself, his household, and his slaves as an everlasting covenant in their flesh. The Jewish people have been circumcising their male children ever since, as have Muslim people. However, Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. I understand that the CPSM has clarified that pursuant to Manitoba law, non-CPSM members can also perform ritual circumcisions and would not be bound by the proposed Standard of Practice. But the main *mohel*, or Jewish circumciser, in Manitoba is a CPSM member, and the mooted change would have the effect of preventing any future Manitoba *mohel* from performing traditional Jewish circumcisions while maintaining a medical practice, which is

standard across Canada. Apparently these equivalent strictures are not enforced in any other province.
I am writing to you in the hope that the CPSM will re-consider the Standard of Practice so as to allow Jewish circumcisions to take place under the care and supervision of a CPSM member outside of a medical clinic or hospital. I can't imagine why the CPSM is even considering this measure. Perhaps a compromise might be to allow Jewish circumcisions to take place only under the care and supervision of a CPSM member outside of a medical clinic or hospital. In that way, you would have a situation where the people who perform the Jewish circumcisions are registered Doctors and thus better able to ensure a safe procedure is done.

I find your proposed restrictions on Jewish circumcision ceremonies very troubling. As a physician in Ontario who has witnessed many of these ceremonies, I see no medical reason for your proposed restrictions.

I understand that you are considering banning circumcision outside of hospitals. Since Jews have performed this ritual for thousands of years without ill effects to the babies, banning it seems unnecessary. Please reconsider, taking into account the negative impact on the Jewish community.

I strongly oppose the ban considered by CPSM.The religious ritual with blessings and family is an integral part of entering the Jewish faith. A clinical setting would not allow the proper setting. I feel the Jewish community should be represented and it's input be considered before such a ban comes into effect.My grandsons were circumcised by a trained doctor who performed the blessings and explained the religious significance of this thousands year old tradition.I would not like to see this celebration of faith and family done away with by requiring the medical procedure to occur in a setting that can't accommodate the truly magical entrance into our faith.

I have just read with deep concern that the College of Physicians & Surgeons of Manitoba (CPSM), which regulates the medical profession in the province, is considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital.
There can be no doubt that, if enacted, this would constitute a significant infringement on the important Jewish lifecycle event of *brit milah*. Jewish circumcisions are typically family events hosted in homes or synagogues, together with a Minyan (a Jewish quorum at least 10 Jewish men so that special prayers may be said) and involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital.
In my respectful submission, such legislation would abrogate a fundamental religious right and would be a retrograde step, as observant Jews, who wished to arrange a *brit milah* in accordance with Jewish law, would, of necessity, have to obtain the services of a person who was not a member of the CPSM. Such a result would be inimical to the public interest, and would be potentially prejudicial, as such a person may be less qualified than a CPSM member.

Jews have had circumcisions for literally thousands of years, and such circumcisions have, in the main, been performed outside of a medical clinic or hospital, without untoward consequences. It is difficult to see what benefit the new proposed regulations would provide. The prejudice, however, would be profound. As a concerned Jew, I respectfully urge the CPSM to reconsider the regulations so as to prejudice so basic a Jewish law.
If you let your insurance company dictate policy over an illogical requirement, you have succeed in alieinating just about every interested stakeholder . Non-Physicians can cut a foreskin, but only a registered physician provides the assurance of quality care. Obviously, that is a prime value we can all share. There is no clinical need for in-faculty care. (My god, this is similar to abortion restrictions in "red" states.) And to allow only non-physicians the right to perform "surgery" in non-clinical settings just seems like restraint of trade. (A touch of levity). You have my best wishes for digging yourselves out of this one. And remember the first rule of digging yourself out is....
Please continue to allow the Jewish ritual of male circumcision to be performed as it has always been allowed to outside of a hospital or medical clinic. Disallowing this will severely restrict Jewish ritual practice in Manitoba.
What exactly are you referring to in « slippery slope « comment? Would this change impact on Arabic communities as well?
We understand that a Standard of Practice is proposed which would ban Manitoba CPSM members from performing circumcisions outside of a medical clinic or hospital. This would constitute a significant infringement on the important Jewish lifecycle event of Jewish circumcisions which are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. We understand that the main Jewish circumciser (*mohe*l) in Manitoba is a CPSM member, and the proposed change would have the effect of preventing any future Manitoba *mohel* from performing traditional Jewish circumcisions while maintaining a medical practice, which is standard across Canada. We very strongly oppose this proposal.
Please do not prohibit infant circumcision outside the hospital! Jewish tradition calls for a ceremony surrounding circumcision and it is always done in an antiseptic, careful manner; it has been conducted this way for thousands of years and is an important ritual. You can certainly require training for those who conduct circumcision or licensing, but do not interfere with a centuries' old Jewish custom, please. I don't think the statistics would

indicate that there have been grievous injuries very often; great care is taken. After all, we're talking about a baby's reproductive capacity here -- it's no joke.

I am hoping you are considering this as a health measure, not because there is an anti-Semitic attitude at the College. In any case, please reconsider.

Hello. I am writing, as both a member of the Jewish community and advocate of children's rights, to express my enthusiastic support of a ban on circumcisions outside of a medical clinic or hospital.

For far too long has this cosmetic procedure been permitted to take place without regulation or under necessary surgical conditions. With no reporting requirements and no required medical or cosmetic surgery training, far too many helpless infant boys have been placed under unnecessary risk.

D. Bollinger (2010) estimates that approximately 9.01/100,000 newborn male circumcisions in the USA results in death. That equals 117 unnecessary deaths each year in the USA at the time of publication. It is likely that Canadian statistic are similar, adjusted for population. (Please find the link to the study published in the journal Thymos Journal of Boyhood Studies, below.)

Special interest groups such as B'nai Brith Canada claim to speak for all Jews and to defend the religious rights of Canadians. However, they do not speak for all Jews and have no authority to do so. They, in fact, speak for only a small (but vocal) minority of Jewish people. They also do not speak for or defend the children subjected to circumcision outside of clinical or hospital settings. As these children can have no knowledge of — or perspective regarding — the religious genital cutting procedure being done unto them, they cannot consent to a cosmetic procedure being performed outside of a safe medical setting.

I reject the notion that this proposed change threatens a fundamental aspect of Jewish life in Manitoba, or that there is a valid argument for a so-called "slippery slope". There is no prohibition on circumcision being proposed and no prohibition on a hospital-based procedure including the complete religious components. As for the none-religious components of a meal and speeches (as cited by B'nai Brith Canada as "important" Jewish traditions), this is of no concern for the CPSM, and can continue as normal in the home or place of worship. Rather, the 'outrage' to this proposed change seems to be a thinly veiled attempt to allow Jewish doctors to continue to moonlight as ritual circumcisers (Mohelim) and bill outside of the provincial health system.

I applaud the efforts of the CPSM to finally regulate this religious surgical procedure and bring it into the 21st century. There is an opportunity here to diminish the number of infant deaths and serious unforeseen adverse outcomes by ensuring that *all* boys, who's parents elect for them to be circumcised, receive a safe and competent surgical experience in an

appropriate medical setting. The CPSM can set an example and precedent for the rest of Canada, and to the world, that modern medicine and religious freedom can coexist. It is the duty of the CPSM to minimize potential medical harms, and therefore restricting ritual male genital cutting outside of a clinic or hospital falls well within that mandate.
I am concerned about your proposed limitations as to where your members can perform a circumcision. The Jewish circumcision ritual is thousands of years old and represents a mainstay in defining Jewish identity, no different today than it was in the Roman empire, the ancient Greek polities and ancient Persia. Any limitations on where the circumcision ceremony takes place is bound to have negative repercussions on those Jews living in smaller towns and on those Jews for whom circumcision is of minor cultural import. A religious/cultural institution that has been around successfully for thousands of years hardly requires regulatory import. It is hubris to think otherwise.There is nothing that needs to be fixed here.
Your new proposed changes to circumcision practices will have a negative impact on the Jewish community. Please consult with members of our community before bringing in such drastic changes that will have negative effects on our ability to practice our religion.
Please take note that your proposed legislation, regulating circumcision to hospital facilities only would be a hardship for the Jewish religious community which has historically supervised this procedure on its own terms … with the highest of professional standards maintained. Your reconsideration is requested to factor in this appeal.
I find it interesting that the proposed changes to the circumcision rules by the CPSM came to light only a matter of days before the deadline to speak up. No consultations done, limited time for public input. Almost as if the CPSM was deliberately trying to prevent the Jewish community from having a say in regulations that directly effect their practices. The latest excuse given by your organizations almost seems to confirm deliberate intent to interfere and cause harm. Non-CPSM members will not be subject to the new rules? So Jews in Manitoba will be barred from access to qualified medical professionals as part of their practices? That is absurd. In fact, this makes so little sense that any argument by the CPSM claiming an intent to reduce harm falls apart. Reducing harm would mean giving access to circumcision services by professionals currently practicing wherever required. Instead, the most qualified people to perform the ritual will be barred from doing so. Given that the only possible outcome of this ruling is to increase harm to the Jewish community, the only question left is of motivation. Either the members of the CPSM making this decision are incompetent, or they are deliberately attempting to cause harm and are malevolent. As it is difficult to believe that physicisians and surgeons are incompetent, a malevolent intent to harm is logically the most likely motivation.

It is horrifying to see one of our province's most important institutions outright engage in anti-Semitic behaviour. If you have any integrity, you will rescind these proposed changes and apologize.
I join all others who demand that circumcisions of newborns should be allowed in Manitoba for the Jewish community as they were done for thousands of years: by Jewish experts in this procedure, wherever the families wish these events to happen.
This event is a community event. If this is followed through it breaks down or heritage, our family values, it is prejudice of our faith, and it destroys our communities. I see this as a direct attack and is very anti semitic. The most beautiful experience is all to be gathered and being a part of this event. It is a spiritual commandment also command for our faith to observe for centuries and as an observer at events up holds our values. Please do not allow this to harm our communities.
All health Practitioners who come up with these idiotic decisions need to go back to school.
I'm contacting you regarding the new proposal for Standard of Practice that would ban performing circumcisions outside medical clinic or hospital. I wanted to let you know that circumcision is one of the fundamental traditions of the Jewish people which has been performed for thousands of years and is not something that could be lightly dismissed or changed. The act of circumcision is not only a medical procedure as you may think, but a very profound spiritual action that is basic to our faith. Interfering with this would have a very negative impact in the community, and I think it is an act of interfering with freedom of religion as well. I urge you to reconsider this proposal and review it with the proper religious authorities to understand the implications of these actions before making any decision.
Since I sent my last email, I have learned more about the circumcision proposal by the Manitoba College of Physicians and Surgeons. Namely, that circumcisions take place in a medical clinical setting. Please be aware, circumcisions performed as part of Jewish ritual, the Brit Mila, or ritual circumcision is not simply a medical procedure. It is a Jewish practice steeped in the Torah, practiced across Jewish communities for thousands of years. The Brit Mila is a "physical symbol of the relationship between G-d and the Jewish people." (Chabad.org) To institutionalize this ritual practice, would mean depriving Jewish families of a central Jewish rite and religious freedom. Please do not allow this intolerant and insensitive proposal to go forward.
Please please please! This is a time honoured tradition that has still of the test of time, what could possibly be the reason for messing with it now? Perhaps antisemitism? Some of your best male doctors are Jewish ! They have suffered no ill effects if it ain't broke don't fix it:

We would encourage you to reconsider the new proposed practice by The College of Physicians & Surgeons of Manitoba (CPSM) that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital..
As you are probably aware, this would constitute a significant infringement on the important Jewish lifecycle event of brit milah. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital.
As I understand it, there is no evidence that the CPSM specifically consulted the Jewish community about the proposed change, despite its obvious impact on Jewish life in Manitoba. It is also not clear what prompted the proposed restrictions, and B'nai Brith is not aware of equivalent strictures in any other province.
My question is why?

This is further to my note to you of 15 July 2021.
Here are two further points:
(a) Hospital or clinic circumcision does not guarantee that the circumcision will be properly done. The key is that the circumciser (mohel) is qualified and trained in the procedure.
My son was born in the Ottawa Civic Hospital in 1977. We asked that he be circumcised. After some initial push back from the hospital, he was circumcised by a non-Jewish doctor.
He later developed adhesions. Fortunately, his pediatrician happened to be Jewish and was also a mohel in Ottawa at that time. The pediatrician solved the problem.
(b) As to my minor procedure before converting to Judaism,despite being performed at a Toronto hospital,it was done by the surgeon in his personal office.There was no immediately available medical equipment. The procedure could have been performed anywhere.

Here is a link to an Ontario association of Jewish circumcisers. Each is a physician. Some are women.My guess is that any of these doctors would be happy to speak with the CPSM about circumcisions in a synagogue.
Here is a link to a survey of circumcisions in Israel in 2001. In that year, there were 19,478 circumcisions performed. 66 had complications. Of the 66, there were 11 cases where the circumciser was a physician. In the remaining cases (55 of the 66),the circumciser was not a physician.
By restricting ritual circumcision of new Jewish baby boys you are in fact making life very difficult for the Jewish community of Manitoba. Why do you not see what is wrong with that? The effects of your plan reek of the antisemitism of Europe, then and now.

We categorically object to this blatant assault on the rights of the Jewish community to practise its religious observances according to its traditions.

I've just about your banning of Jewish circumcision. This would clearly be an anti-Semitic attack! Hopefully, that is not your intent, but it is quite clear.
This is a thousands year old custom, safe, Jewish ritual done by specialists,called Mohels. It is a family tradition.

Banning this, in the cultural manner in which it must be done, in some ,would be like banning Christmas and christenings! These would ALSO be an abomination and attack on the rights of Canadians. Please do not proceed with this despicable plan of banning Jewish ,ritual, circumcisions.
dear fellow Canadians please do not ban jewish circumcision. Brit Milah is a cornerstone of our religion, and not a medical procedure. when taking steps like this, please consult with the community. understand what us done and how. for thousands of years thus same "procedure " has been performed safely and with almost no adverse results. This is frankly an ignorant measure taken without fully understanding what you are doing. you are infringing into our ability to fulfill our religious beliefs. My life also matters.--
I support your proposed Standard of Practice prohibiting CPSM members from performing genital cutting rituals (circumcisions) outside of clinics or hospitals. Hopefully, this will lead to more regulations to protect children from harmful genital cutting.
I am writing to your organization to seriously reconsider limiting the practice of circumcision to hospitals or medical clinics. If you proceed with this it will result in a significant infringement on the important Jewish lifecycle event of *brit milah*. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. Can you advise what prompted the proposed restrictions as I do not believe there is equivalent strictures in any other province. The CPSM does not appear to have considered the serious impact upon the Jewish community of this proposed change and should have consulted the Jewish community before making such a drastic change o this practice. Again this will seriously impact Jewish family tradition.
This is more then 5000 years traditional ritual. No one allowed to change tradition. If our Jewish tradition some of you would like to change, then all Christians should stop going to Churches. How about that?
I believe canada is a country that separates religious practices from politics and other diciplanes. There is no need to have a medical doctor perform the Brit Mila. The person who does these procedures, generally, is a medical doctor who is well trained. The ceremony at home is a long tradition among the jewish people and a very impotant one to welcome the baby. The persons/or doctors that performe these procedures visit the baby latter in the day to make sure the baby is ok. Why does not the medical association stay out of people's business. There has not been casualties as a result of the Brit Mila being done at home. Stay away!!!
I am writing to complain about the initiative to ban licensed professionals (MD) to perform circumcisions in other settings than a hospital.

Newborns circumcision is a Religious practice done for ages by Jewish families that actually benefits enormously by having a registered profesional performing it.

The ban will only increase the risk for babies as it will be indeed performed by people that are not licensed, putting children in danger.

The event is a family social and bounding event that is also seminal to jewish traditions. It is to be performed in a family setting. By having the community attend to it it ensures the passing on of the Jewish traditions and culture.

By banning the potential for licensed doctors to perform it; you are pushing the community to either chose their traditions or the safety of the baby!!

In these times when it is front and center the atrocities done by Canadian governments to kill other cultures traditions (Re: indigenous schools) it is surprising and outstanding that you are pushing to put a difficult wedge on one of the most important Jewish traditions!!

What is this based on? Have you even consulted the Jewish authorities in the region? Why are you pursuing this? It seem like a very arbitrary decision.

You are putting newborn children at risk with this initiative.

One of the most joyful occasions in our family's life was the *brit milah*, Jewish ritual circumcision, of our son.
My wife and I, proud parents, gathered in our home with our parents and siblings and many friends. Our son was wrapped in a beautiful embroidered cloth made for the occasion, to be used again years later to wrap the Torah scroll at his bar mitzvah. There was a veritable feast of potluck food. The many beautiful prayers for the occasion were read and sung by the whole crowd, and we added other joyful songs, meaningful to the family. There was animated socializing and deep spiritual meaning.
In the midst of this gathering, the circumcision of our son was done with care by a physician who is also a trained *mohel*, a ritual circumciser. It was important to us, as to many Jewish families, that he was both a doctor and a religious Jew who knew and understood the meaning of what he was doing: a commandment of the Torah, a mark of our covenant with the Creator, a sign of ancestral heritage and of belonging to a community.
This whole beautiful and memorable experience would not have been possible in a medical clinic.
Please revise your draft standards to **allow** *religious* circumcision in homes and places of worship.

I was concerned to read today about your proposed ban on circumcisions in any non-hospital setting. I am a rabbi and have been involved over the years in dozens of Jewish ritual circumcisions (called a "bris" using the word for covenant in Hebrew).

They done by *mohels*, who are either clergy and/or medical doctors, and all highly trained and experience.

The ritual of circumcision, for Muslims and Jews, is a centuries, even millenia old tradition, and so important for both of our faiths.
Please do not remove this special, important ritual from the Jews of Manitoba.
Thank you for your consideration.

I am responding to your request for feedback, as the chairperson of the Winnipeg Council of Rabbis. The WCOR's membership includes the rabbis of Winnipeg's four largest synagogues and covers all three major Jewish denominations – Orthodox, Conservative and Reform. This letter represents our consensus position on your draft policy limiting religious circumcisions to medical offices only, as outlined in Point 2.1 of your current draft.

Briefly, we are unequivocally against the implementation of such a policy, on four discrete grounds:

1. Religiously: The "Brit Milah" or Jewish ritual circumcision is a centuries-old practice mandated as the first command given to Abraham. It continues to be an important tradition to this day that connects Jews generationally. Indeed, for Orthodox and Conservative Jews (the majority of Winnipeg's significant Jewish population) it is an essential (i.e. mandatory) requirement for newborn Jewish males at eight days. Milah is not a medical procedure but a religious one. The hospital is not the proper setting for Milah. It belongs in the sanctity of the home and synagogue. To change that centuries- old status quo would have very negative consequences to the nature of Milah.

   The medical procedure itself is embedded in a much broader religious ceremony. There are accompanying ritual blessings and practices involving a number of other individuals both before and after. These include: the baby's godmother or godfather bringing the baby into the room, the "sandek" who holds the baby's legs during the circumcision, the parents who recite blessings, the presence of a full glass of wine, and of course the person doing the circumcision (the "mohel") and very often, a rabbi. Parents advise everyone present of the Hebrew name that they have given the child, who they are named after and the stories they associate with the name. Again, we must reiterate that Milah is not a medical procedure but a religious one.

2. It is a community event: Simply stated, a "bris" is a cause for celebration, as it announces to the world that this child has entered the covenant with God. It is a major life cycle event where the parents invite family and friends to their homes or to a

synagogue to witness this special event. Again, this is far beyond what can be done in a medical office.

Although there are no religious laws with a Milah being undertaken in a hospital, it is at its heart a community-based ritual done in private homes and synagogues, and to move it from those places would significantly affect the spiritual character of Milah.

3. Medically: There is no evidence to support that brit milah is not safe. I will paraphrase one of my colleagues, who expresses quite well our collective frustration toward your draft policy, as follows:
    - "Why now? What's the problem? Jews have been doing this for DECADES with trained doctors. In fact, our Jewish community in Winnipeg is fortunate to have Jewish doctors who have taken specific training in this procedure and the accompanying rituals and blessings, and have been performing this task outside of their offices and in non-hospital settings for years." Currently, two Jewish doctors have undertaken this responsibility for Manitoba's Jewish community. Both are noteworthy for being impeccable in their hygienic practices at all times in these settings.
    - Again, why now? "We could understand if there had been accidents or injuries or high risk to the kids. But it's simply not the case. Medical techniques have improved over the years, and with the current use of a clamp, it's basically as foolproof as anything medical can get."
    - "Births are allowed in the home. Births! And not even with doctors but midwives. And the risk of something going wrong or death is exponentially higher in delivery than in circumcision. It's not even comparable, really."
    - Furthermore, "every other province allows for ritual circumcisions to be done outside a doctor's office. Why here? Why now?"
4. The impact of this draft proposal: Because of the hardship the proposal would create, we fear that many families who would currently do a traditional Brit Milah would opt for a non-halakhic procedure (one that does not comply with Jewish religious law). We see this as infringing on the religious rights of Jews wanting to practice their religion freely.

As the spiritual and religious leaders of Winnipeg's Jewish community, we urge you to reconsider and to abandon this policy initiative, as it oversteps the religious requirements and community framings of this central Jewish tradition, for medical reasons that are simply not apparent.

Please do not hesitate to contact me or any of my colleagues for further clarification. We appreciate your serious consideration of our position on this matter.

Circumcision of male children, as a fundamental expression of the Jewish people's sacred covenant, has been practiced for thousands of years with no apparent ill effects on the sexual functioning Jewish males, no evidence of trauma, either at the time or later, and a complication rate of less than half a percent. Thought those millenia, circumcision served a protective function for both these men and their sexual partners and, although modern

hygiene has improved the situation, continues to mitigate risk for syphilis and gonorrhea, and there is evidence supporting adult circumcision to reduce HIV acquisition, although the risk of complication rises 10-20 old after infancy. In the absence of compelling reasons to ban male circumcision, doing so can only be seen as a targeted act of Antisemitism. Furthermore, most will surely choose to simply pack up their infants and head across the provincial border, but some may feel forced to do what our fore-bearers did, to practice sacred rituals in private , without legitimate oversight, which would likely also create reluctance to seek timely medical care, should it be required. Nothing good can come of this. We need our pediatricians to spend their efforts on real and pressing concerns, such as: inadequate support for families at risk; inadequate mental health resources for children and youth; inadequate access to speech/language and occupational therapy; a paucity of intensive early intervention for children with developmental or learning challenges; an absence of resources to cover the drugs, glasses, and dental needs of needs of children in low-income families who are not receiving social assistance; etc. Core Jewish cultural and religious beliefs and practices have demonstrated extraordinary persistence, importantly under-pinning family and community structures notable for their resilience. We need our pediatricians to build up rather than tear down and this would be just that, an 'attempted' tearing down, a source of dissent, a vote for intolerance and everything it breeds - with nothing accomplished in return.
“The CPSM does not appear to have considered the serious impact upon the Jewish community of this proposed change,” said Michael Mostyn, Chief Executive Officer of B’nai Brith Canada. “The time is now for Canadian Jews to speak up against attempts to restrict this fundamental Jewish religious and cultural practice. “While this may appear to be a minor change to some, it would threaten to fundamentally change the lives of many Manitoba residents. We are also concerned about a potential slippery slope toward more critical blows to Jewish life that we have seen in other Western countries.”
AS we know circumcision is not medically necessary. and we know that the Canada Criminal Code protects Female genitalia from excision, ablation or alteration, and the Canadian Charter of Rights and Freedoms requires gender Equality, you can help move Canada to a position of agreeing with all other medical associations in the world that state that circumcision is not recommended.. and you can state categorically that you agree that it should be banned comletely. In regards to Religious or cultural aspects, please be strong as Religious Rites do not trump Human
I am a former Winnipeggers and also of the Jewish Faith. The thought of banning members from practicing an ancient ritual sacred to Abrahamic faiths - Jewish and Muslim - is damning and ill advised. I am a 2nd generation Canadian and my family has roots to Winnipeg for over 120 years. The Jewish community had been an integral part of Winnipeg for longer. I am against this resolution in form and in its entirety.

It should be withdrawn as it alienates many and two communities and singles out a faith based practice. If citizens don't want circumcisions they they have that choice. Members of the Abrahamic Faith's should not be forced to choose who does it based on your resolution. This isn't an abortion issue. Take that stand and stop your members doing that. See how far that gets you!
I understand that your organisation is proposing a ban on its members from performing circumcisions outside of a hospital or clinic. Is this a deliberate attack on the rituals of the Jewish community - or is it the case that "Evil is wrought/for want of thought/ more than for want of heart"? I am not Jewish myself but, as a devout Christian I acknowledge a great debt to the Jewish people - not only in religious matters but in various other areas. I have Jewish friends and am well acquainted with their customs. It appears that the proposed ban may be due to appalling ignorance; I would not like to think that it is due to anti-religious bigotry or racial discrimination. The fact is that, where Jews are concerned, circumcision is more than just a medical procedure; it is a major social and family event, often accompanied by a celebratory meal - comparable in this regard to a wedding. Such elaborate celebrations cannot easily be held in a hospital or clinic. I hope that you will take notice of the above facts and not go ahead with the ban.
People are giving the Jewish people a hard time and now you are too! It is a religion ceremony and you should leave it alone. Mind your own business and leave us alone. You have no right to interfere with our religion ceremonies. Please leave it alone.
Hello, you guys received backlash due to how one of your policies would potentially affect circumcision, especially religious ritual circumcision. Your response was "the standard will not infringe on any human or religious rights and freedoms whatsoever." Why would you guys say this? This seems to be completely ignoring the fact that many people around the world, (especially in Europe, but also in Canada) view non-therapeutic circumcision of children as an unethical human rights violation. Furthermore, forcing a religious ritual on a child that permanently alters their body (i.e. circumcision) is akin to religious branding. Even though the College of Physicians and Surgeons of Manitoba has stated they are unable to ban circumcision, could you guys please at least try not to trivialize the harm of forced genital cutting? Could you guys avoid ignoring the fact that contrary to your argument– many people, including medical professionals, do not see a prohibition on circumcision as a human rights violation like you insinuated, but rather, upholding the basic human right to bodily autonomy and religious freedom. It is not fair for CPSM to continue to pretend that the ethical debate with regards to circumcision does not exist.
I have became aware of the new standards of practice you wish to put in place regarding office based procedures (found at: https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcpsm.mb.ca%2Fassets%2FConsultations%2FOffice-BasedProcedures%2FSoP%2520Office%2520Based%2520Procedures_Consultation.pdf&

data=04%7C01%7Cobp%40cpsm.mb.ca%7C5730c2709a4d4fb5f8aa08d94ae83296%7C80dcc43e306749a8825db77b5caa9cca%7C1%7C0%7C637623183401481029%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=Wh8Eaa0d9BopCXmhrfd7MWcVh4NolvWIkDljrxA7Wq4%3D&reserved=0), they are a great step forward to keep all people safe with regards to these non-medical surgeries. Other countries (like Denmark I believe) have already had these in place for many years (at least with regards to infant circumcision).
Why is this antisemitic practice of thinking of banning our tradition of thousands of years old of Bris Millah taking place.
Circumcision for Jews is a fundamental religious practice. It has been done and practiced for thousands of years. Anyone trying to ban it or change any regulation is meddling with long religious practices, therefore will be considered an anti-Semite!. No two ways about it!!! Please make sure not to interfere in such fundamental Jewish practices. Just stay out of it.
We are disturbed by your proposal to ban male circumcisions in Manitoba, including for religious purposes, in non-hospital settings. This move will have a negative impact on Jewish religious observance in your province. Male circumcision is an important lifecycle event for Jews, performed on the eighth day after birth on males. It is often performed by a qualified mohel, a trained, certified professional , often a doctor, in the Jewish community. It is often held in the family's home. This is a practice which Jews around the world have been doing for centuries in our communities. Your ban is an infringement on our religious rights and is disrespectful to Jews in Manitoba and for that matter, in every Jewish community.
I would like to assume that the proposed Standard of Practice Regarding “Office-Based Procedures” was not intended to restrict the practice of Jewish ritual circumcision in homes and synagogues by qualified physicians who are also qualified in Jewish religious practice. If my assumption is correct, then kindly modify your proposed standard to ensure it is clear that Jewish religious practice is not affected. On the off chance that the standard IS intended to affect Jewish religious practice – really? I cannot imagine anyone needs to be told how unnecessary, offensive, and discriminatory that would be. Thanks in advance for your consideration.
I have heard about the possibility of your stopping circumcision in Manitoba. This issue is a spiritual and religious one for Jews and our community. It is NOT a decision for your College to make. If a physician decides not to do this act then others may do so. We have had this practise for thousands of years and we have had little difficulties with it. Please do not stop this holy practise. It is done with love and goodwill.

Please exclude Jewish male circumcision from your drafted Standards for Medical office practice.
This ritual is safe when performed by experienced practitioners and current practice leans to physicians performing this in the community.

It has come to my attention that the College is seeking to ban all male circumcisions outside of a hospital setting. I am writing to you, as a Jewish mother, to express my concerns about such a move.

My son was circumcised approximately 21 years ago, in October of 2000, when he was eight days old. It was important to my then-husband and I that he be ritually circumcised and that the *mohel* (circumciser according to Jewish law) also be a medical professional. As we were living in Toronto, we engaged the services of Dr. Aaron Jesin, a family doctor who had been performing ritual and medical circumcisions for many decades. Eight days after our son's birth was a Saturday, the Jewish sabbath. Although all work and driving is suspended on the Sabbath, Dr. Jesin, who is strictly religiously observant, walked approximately an hour from his home at one end of the city to my mother's home, where the bris was performed. A crowd of people arrived at my mother's home that afternoon. XX was the first grandchild born to my generation on my mother's side and on my father's side. He was also the first baby born to my ex-husband's family, some members of whom survived the Holocaust. My father-in-law had no family present, as he only has a few scattered cousins around the world due to his family's experiences under the fascist regime in wartime Romania and later communist oppression. The joy in the room at the act of welcoming a new baby to the Jewish community was palpable.
I have no idea what happened during the brit milah ceremony itself, as I have a fear of needles and medical instruments, so I stayed in another room. As soon as the job was done I took him to a quiet room for a cuddle and to nurse. He was upset, but soon calmed down. After the baby was calm, Dr. Jesin showed us how to care for him after the procedure and what to watch for in case something went wrong. He had almost completely healed by the end of the next day. There was no infection at all. Though I don't talk about his penis with him, he has never expressed any unhappiness with the result. If he had had a problem when he was younger, I am sure he would have come to me or to his dad, who is now a doctor himself. Anything that happens to his penis now is his own problem and not the fault of Dr. Jesin.
If there is a record of children who have experienced post-circumcision infections due to the procedure having been done outside of a hospital, please produce it. I would be very surprised to see such a record.
The Jewish community is happy to engage the services of a mohel who is also a member of the Medical College. However, before the advent of modern medicine, many mohelim were not medical doctors, not even in the pre-modern conception of the term. There are still a number of mohelim around the world who aren't medical professionals in any capacity. I personally would be happy to recommend a mohel who was a nurse or a nurse-midwife to a friend, but would not want to see a mohel with no medical training and oversight performing

this ceremony. I worry that if the College limits its members from helping the Jewish community from celebrating the entrance of a new baby boy in our homes and synagogues, some people may engage the services of someone who is not bound by the Medical College or the College of another medical profession. Please take the time to consider this recommendation carefully. It is unlikely that the vast majority of Jews will abandon infant circumcision, as this is a religious commandment that is referred to many times in the Torah, the oldest Jewish sacred text. Instead, members of the community are more likely to abandon medical infant circumcision.
I am a member of the Jewish community and the mother of three sons, all of whom had a ritual circumcision performed by a medical and religiously trained expert. For my first and second sons, hospital stays were longer and the bris was performed in the hospital. By the time of the birth of the third son, because of shorter hospital stays after birth, this ritual was performed in our home. At all times, my children were safe and being expertly cared for. Your ban on not allowing medical professionals to perform this rite in locations other than a hospital is a serious breach of Canada's human rights code and a breach of freedom of religion. I am expressing my strong opposition to this measure and I join many Canadian citizens in this opposition.
Please do not include Jewish circumcisions as part of your draft legislation. For generations my family have had these religious ritual services done at our homes in a safe and sterile manner. It is a sacred vow between our nation and god. To move it to a hospital setting would change the total feeling of the service. My son, nephews , and father have had their circumcisions done at home as per our tradition. I also hope that my soon to be born grandson will be able to have his circumcision at home with all the appropriate members of the community present and involved.
I was surprised and disturbed to hear today of the College's proposal to ban male circumcisions, including for religious purposes, in any non-hospital setting which would constitute a significant and unjustified impingement on Jewish Manitobans' right to religious freedom, and would potentially spark a legal challenge. I have serious misgivings with the way in which this potential change has been rolled out. Despite the obvious and serious effect this would on Manitoba's Jewish community, the community was never consulted. *Any move to ban circumcisions outside of hospitals would have a significant and entirely negative impact on Jewish religious observance in Manitoba. For Jews, male circumcisions, typically performed on the eighth day after an infant's birth, are a critically important lifecycle event, rather than a mere medical procedure. Requiring all circumcisions to take place in a hospital materially interferes with Jewish religious observance.* *I fully expect the College to comply with its obligations under the Charter of Rights and Freedoms and rescind the proposed Standard of Practice or amend it to exclude ritual male circumcisions.*

I have read that the Manitoba College of Physicians and Surgeons is proposing to prevent doctors from performing Jewish ritual circumcision, brit milah, in homes and synagogues. I think that the proposed change to the Standard of Practice is an attempt to fix a problem that does not exist. I hope that the College will comply with its obligations under the Charter of Rights and Freedoms and rescind the proposed Standard of Practice, or amend it to exclude ritual male circumcisions.
As Christian, I entirely support the view that a Bris is a centuries old Jewish Religious ceremony and requirement for Jewish males. I sincerely hope that the ruling that a Bris cannot be performed OUTSIDE a medical facility will be condemned as interfering with religious practises and freedom.
It has come to my attention that the proposed OBP document could have the effect of precluding physicians from performing ritual circumcision. Such a change would have devastating consequences - apparently for no good/evidence-based reason. In my humble opinion it must be reconsidered and such restriction eliminated from the OBP proposal. Thank you. Wishing you well in your deliberations.
I am a physician in Ontario who has been in community practice for 44 years I am also a member of CPSO, a peer reviewer and an out of hospital site inspector for CPSO. I am also Jewish and have an interest in allowing physicians to be able to safely perform ritual circumcisions outside of hospital settings, such as a synagogue or a home. Why is this important? One of the most important rituals in Judaism is the male circumcision. Although you might consider this not traditional, it is in fact part of many different cultures tradition, and has been for thousands of years. It is however, more than just a simple removal of a foreskin. It is not done for medical or health reasons, as some might suggest. It is for a commitment to maintain a tradition that values social justice, fairness, and the value of human life. It places the father/parents in a position to outwardly express to their community that they are going to continue these values and teach this child those values. In a complicated present and future world, these values are important for a safe society. It is for this reason that this tradition is important. Not just the physical act. It is a highly emotional time for all, but one that is very pivotal in one's life and family life. It is important that this be done safely, and physicians are always taught to support that directive. The circumcisions in Manitoba will be done regardless of a regulation by cpsm. I think the Board of CPSM should allow Jewish circumcisions to be done by physicians and be done safely outside the hospital as part of a regulated health system.

Why are you proposing that physicians cannot perform male circumcisions? This proposal is antiemetic. Why are you restricting an important ritual service to the Jewish community?

My niece lives in Winnipeg and has a young family. It would be a shame if this change would affect our family, or any other family.

22% of all Nobel Price winners are circumcised Jews. Proof enough that circumcision, as ordered by G-D, works miracles.

I'm writing you to express my concerns regarding a plan to further regulate circumcisions performed outside of a medical clinic or hospital.
Lately, I came across the information that the College of Physicians & Surgeons of Manitoba (CPSM) is considering a new Standard of Practice that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital.
If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of *brit milah*. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital.
I understand that non-CPSM members can also perform ritual circumcisions and would not be bound by the proposed Standard of Practice. But the main *mohel*, or Jewish circumciser, in Manitoba is a CPSM member, and the mooted change would have the effect of preventing any future Manitoba *mohel* from performing traditional Jewish circumcisions while maintaining a medical practice, which is standard across Canada.
There is no evidence that the CPSM specifically consulted the Jewish community about the proposed change, despite its obvious impact on Jewish life in Manitoba. It is also not clear what prompted the proposed restrictions. I'm also not aware of equivalent strictures in any other Canadian province.
The CPSM does not appear to have considered the serious impact upon the Jewish community of this proposed change. The current proposal restricts the fundamental Jewish religious and cultural practice.
I urge you to reconsider and cancel the proposed regulation.

As a graduate of the **University of Manitoba Medical School (class of '88)** and a **practising Jew**, I must add my voice to those who have expressed their concerns regarding the proposal to ban circumcisions outside a medical clinic or hospital. Traditionally a Jewish "Bris" or Brit milah, the celebration of the covenant of being Jewish, is a joyful event in a synagogue or family home, celebrated by family members of multiple generations to mark the joy of the continuation of the Jewish people. A hospital is not an appropriate venue for the family religious gathering involved.
Frequently, as is the case in Manitoba, the cirumciser or "mohel" is a physician, which gives additional protection to the safety and well-being of the baby, (as well as religious knowledge and training in the procedure). The proposed changes would essentially FORBID a physician from acting as a mohel in the traditional way, thereby almost forcing the community to use a NON-PHYSICIAN mohel, which would certainly NOT be safer.

I am certain that this interference with the religious life of Manitoba's Jewish community was in NO way intentional, but I must ask that you reconsider the parameters involved. Thank you
I am writing to express my objection to the proposed change in law regarding circumcision. If enacted, this would constitute a significant infringement on the important Jewish lifecycle event of *brit milah*. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. As well, when done in the home, mothers can nurse their babies immediately and provide comfort. Having witnessed both hospital and non-hospital circumcisions, I can say with confidence that the later is preferable whenever possible and sacrifices nothing when it comes to safety.
I am a retired family physician who practiced in Ontario. I was told that tomorrow is the deadline to contact you . I received information only today re Jewish Ritual Circumcisions can only be done at a hospital or medical clinic. Since I was not given the reasons for this decision I cannot judge its merits. It will make it extremely difficult for this Ceremony to be done properly. I tend to think that ultimately it will fall into the hands of retired previously licensed Manitoba M.D.s who have experience in this event. I believe that you should postpone this decision until you have had transparent discussion with Jewish community leaders and rabbis .
This safe procedure should be permitted by MDs outside of hospital. It also saves the health care system a lot of needed money.
I wanted to get some context for this policy and try to understand the implication for family physicians, or any physician, who does jewish circumcisions, brit milah, at homes or in synagogues. Does this standard preclude this from happening now? It seems this would be a significant change and would want to know the rational for such a drastic change based on risk and evidence? I would also hope that there has been consultation with those in the community that may already be doing this as well as the Jewish Community, to understand the impact of such a change.
The suggestion of doing all circumcisions in a medical facility will interfer with some religious practices which goes against our charter of rights AND will substantially add to the cost As a pediatrician I see no benefit only harm if this action is taken
Why would you restrict a physician from performing this act outside of hospital/medical clinic, but allow it to be performed by a non-physician? What could the College possibly be thinking?

You allow home births by nurses. Why can't a physician do a home circumcision? What is your rationale?
I am shocked to hear plans by the CPSM to ban circumcision outside of clinics and hospitals in Manitoba. This, while may be well intentioned with regard to patient safety, goes clearly against Jewish law, traditions and implies either outright bigotry or unintentional ignorance. As a Physician and a Jew, I am appalled that this proposal is being considered at all in Manitoba or anywhere in Canada. I certainly hope that you will re-consider this proposal.
Your proposed change to CPSM Standard of Practice re circumcision is a direct attack on Manitoba's Jewish community. There is no evidence of a need for such a change, and it will negatively impact Jewish citizens of the province. Please consider abandoning this unnecessary change in practice.
It has come to my understanding that you are considering preventing your doctors, who are certified and qualified, in the Jewish ritual circumcision of a male child. I'm not sure what consideration this has been given. But I am confident that if you asked anyone who is Jewish in your College whether there is any issue with the practice, you would find nobody has an objection. I have 6 grandsons who were all circumcised by an experienced MD, in our home in sterile conditions and according to our practice for hundreds of generations. There were no reasons to do it elsewhere and it probably would have been difficult to get space in a hospital for our approved MD to do the procedure, especially while Covid is still around.
I was devastated to hear about the new Standard of Practice being considered that would ban CPSM members from performing circumcisions outside of a medical clinic or hospital. I cannot believe that the CPSM would consider this at all given the fact that it would infringe upon the religious freedom of Manitobans. Jewish Manitobans deserve to practice this most fundamental tenant of their religion in a safe manner. If you do this, it will push this practice underground. I am very very concerned about this, and it smacks of antisemitism.
In this age of Equity, Diversity and Inclusivity; when blacks, Muslim and Indigenous people are receiving extensive attention to their plight, how could a Canadian province dream of restricting the religious freedom of Jews? This is a terrible affront to the Jewish people of Manitoba and reminiscent of the slope that lead to horrendous atrocities against the Jewish people of Europe.
I was very upset to hear that you plan to ban circumcision outside hospitals or medical clinics. Ritual circumcision has been practiced safely for centuries outside of a medical setting.

Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. Please reconsider your decision so that Brit Milah -ritual circumcision can take place in a setting more conducive to this religious practice. Please allow your members to perform circumcision outside of a medical clinic or hospital.
I am aware that Manitoba plans legislation to allow only medical doctors licenced in Manitoba to perform all circumcisions including Jewish Ritual circumcisions from now on. I am a retired Urologist of Toronto and a FRCSC and therefore very experienced in the procedure and especially in infants. I am also Of the Jewish faith and have witnessed many religious circumcisions. This ritual has been part of the Jewish faith for more than 2000 years . In my life time and more than 45 years as a Urologist I have not seen nor heard of untoward events carried out by the appropriate religious and trained person including my son. It is inappropriate for a law to be passed preventing this custom to take place in Manitoba when done by a "mohel" who is a trained individual and often a Physician. Please reconsider your actions and leave this Jewish ritual to the Jewish faith to monitor.
I understand that physicians are no longer to be allowed to perform ritual male circumcision outside a hospital setting.Not only is it unacceptable that there was little if any discussion with faith groups affected by this but it seems a step backwards and unnecessary to mandate this to a hospital when higher risk procedures are undertaken in home and ambulatory settings. If this is a way of interfering with religious rights practiced for centuries then shame on the College. It brings the regulation of medicine into disrepute ..Parents may very well prefer a physician performing the circumcision in a home setting and their wishes should be respected.
As a physician in Ontario, I am writing to express my concern with regards to the proposed change by the CPSM regarding ritual circumcision. Physicians have traditionally served the Jewish community by performing ritual circumcisions and maintaining a high level of quality care for the newborns. Ritual circumcision is often performed in an intimate setting in the home of the parents. In many ways it is akin to the role of the midwives who offer high level care in the home of the patient while not compromising the quality of the care they provide. The proposed changes would severely penalize the Jewish community who routinely perform ritual circumcisions in the home setting. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. The focus of health care should be on quality, and not location.
We, the members of the Ontario Liberal-Minded Association of Mohalim (OLAM) wish to express our profound concern about the proposed change in the "Standard of Practice –

Performing Office-Based Procedures" that would disallow physicians licensed in the Province of Manitoba from performing circumcisions outside of a clinic or hospital.
OLAM is an organization of physicians licensed by the College of Physicians and Surgeons of Ontario, who perform ritual circumcisions for Jewish infants in a ceremony known as Brit Milah. Brit Milah is a fundamental and extremely important life event in which an 8-day old boy is welcomed into the Jewish people. The ceremony and procedure are traditionally done in the home, by a highly skilled individual known as a mohel. Although some mohels are not physicians, many are, and they provide a service to the community in which a circumcision is done in the home environment with aseptic surgical technique and post-surgical care that is indistinguishable from that provided in a clinic or hospital.
There is no evidence that surgical outcomes or complications differ between a circumcision performed in a home environment by a mohel and a circumcision done in a clinic or hospital. There is no valid reason why a licensed physician with appropriate training and skills should not be allowed by the CPSM to perform this sacred ritual in the home environment. This is an issue of the family's right to exercise their religious freedom by bringing their new son into the Jewish people as Jews have for millennia.
We urge the CPSM to re-evaluate this position, and to continue to permit physician mohels to perform Brit Milah outside of the clinic and hospital environments.

If enacted, the restrictions you are considering would constitute a significant infringement on the important Jewish lifecycle event of brit milah. Jewish circumcisions are typically family events hosted in homes or synagogues, involving a celebratory meal, blessings and speeches. None of these can practically take place in a medical clinic or hospital. The person who does this is called a 'mohel' and the current one is a member of CPSM and would therefore be restricted from performing this rite of passage, as would any future physician who would replace his services in future.

We ask you to reconsider, as this law would constitute an infringement on our religious rights.

1. Standards

The proposed new standards appear to anticipate improved real world consequences. In the case of ritual circumcision, the risks of infection (in the hands of a physician) are likely far lower in the community than in an accredited teaching hospital, where antibiotic resistant infections are an ever present threat. Accreditation for compliance with the highest standards is not a guarantee of safety.

2. Practice of Medicine

The College's standards indicate that "cutting into tissue" is a reserved act, which I understand to mean reserved for licensees of the College.
B'nai Brith was informed by CPSM that "non CPSM members can also perform ritual circumcisions." How can the College justify excluding a licensed doctor from "cutting into tissue," a reserved act, while, at the same time, acceding to the procedure by

an unlicensed person? Surely, excluding licensed doctors from ritual circumcision is counterproductive!
I would like to voice my objection to the new restrictions being considered for doctors performing ritual circumcisions outside of the hospital or medical clinics. These have been carried out for many years without incident and is an event that is important in the Jewish faith following the birth of a male child. It is quite incongruous to think that a non-medical person could perform circumcision but a trained professional (Doctor) cannot. This proposal by the Medical Association is directed at one religious group and should be considered discrimination to one specific religious group. I do hope that you reconsider your proposal and allow physicians to continue to perform this rite as has been done for decades before. I can see no reason why you might even consider this proposal.
I am writing in opposition to banning ritual circumcision in Manitoba. There is no medical evidence to support this ban. The ban would, however, disallow many Jewish and Muslim Manitobans from practicing a basic tenet of their faith. There is no medical reason for this ban and, as such, it should not go forward.
As a graduate of U of M medical and former member of the CPSM, and a proud member of the Jewish faith, it pains me to have to pen this letter. Please stay out of the business of ritual circumcision, and certainly from medical professionals of the Jewish faith, often OB/Gyn or Peds, who traditionally perform these at 8 days of life, at the home or synagogue of the child's parents. 3,000 + years of successful circumcisions should be evidenced based enough for your medical body, to leave this procedure to the "professional" Mohel, those who do or do not possess an MD. Your time would be better spent with serious issues like the COVID debacle in Canada and the sad state of affairs of indigent children. The Jewish community has and always will fend for itself. There is no need for the CPSM to over reach in this manner.
I am a physician in good standing with the College of Physicians & Surgeons of Ontario (CPSO) and troubled by the CPSM proposed policy to prohibit Jewish religious circumcision by licensed physicians in Manitoba outside of a clinic or hospital. Who better than an experienced, trained, and licensed physician to perform such a procedure under strict surgical and infection controlled procedures. Religious circumcision in a home or synagogue has been a practice of the Jewish people for thousands of years. As a regulatory body, ensuring the safety of patients and not deviating from the 'standard of care' is your primary mandate. The standard of care for thousands of years has been religious ritual circumcision outside of a medical facility. In fact, religious

circumcision outside of a medical facility is an accepted standard of care across Canada. It is incumbent on the CPSM to consult with physicians whose scope of practice includes religious ritual circumcision before making any changes to medical practice. It is also incumbent on the CPSM to consult with and collaborate with Jewish leaders in your community as religious practices is a fundamental right protected under the Charter of Rights & Freedoms of Canada.

This form letter was submitted and signed by 205 members of the public from across Canada and internationally.

The College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Ave.
Winnipeg, MB
R3J 3T7
obp@cpsm.mb.ca

July 13, 2021

To Whom it May Concern:

I am writing to you today to voice my concern with an aspect of the College of Physicians and Surgeons of Manitoba's Draft Standard of Practice for Performing Office-Based Procedures (including cosmetic/aesthetic and minor surgical procedures, platelet-rich plasma therapy, and laser service), which is in the public domain for consultation and feedback.

Included in this Standard of Practice are male circumcisions. In section 2.1 of the draft, it is noted ***"members must not perform, or cause, permit, or enable another person to perform any procedure in a location other than a medical clinic."***

The performance of male circumcision by members (physicians) has been included in the draft, however, the performance of male circumcision as part of a brit milah, or part of a religious ceremony, was not explicitly referenced. If brought into force, this draft as it is currently worded would therefore make the performance of a Jewish brit milah by a physician outside of a medical clinic a violation of the College's Standard of Practice.

The brit milah has deep and fundamental roots in Jewish tradition and our heritage. Abraham was commanded by God to circumcise his son Isaac on the eighth day following birth. Since then, Jewish people have faithfully and continuously followed this commandment for thousands of years. A covenant between Jews and God, the brit milah is an indelible physical symbol of our everlasting bond with God. In addition, it is the rite of passage whereby our newborn sons are welcomed into the Jewish community, surrounded by the love of their family and friends. This ceremony is often performed in a synagogue or a family home.

In addition, there is overwhelming evidence in peer-reviewed medical journals of the safety of circumcision and the skill of a trained and certified mohel (the person who performs the Jewish rite of circumcision).

I urge you to consider the implications of this standard, which would infringe on our right to religious freedom, and amend the proposed Standard of Practice to explicitly exclude Jewish ritual male circumcisions.

Sincerely,

[redacted]

League for Human Rights of B'nai Brith Canada
Ligue des droits de la personne

B'NAI BRITH OF CANADA LEAGUE FOR HUMAN RIGHTS
LIGUE DES DROITS DE LA PERSONNE

July 12, 2021

Dr. Jacobi Elliott and Dr. Anna Ziomek
President and Registrar/CEO
The College of Physicians & Surgeons of Manitoba
1000-1661, Portage Avenue
Winnipeg, MB
R3J 3T7

Dear Dr. Elliot and Dr. Ziomek,

I am writing to you on behalf of B'nai Brith Canada, a leading Jewish human rights organization and opponent of antisemitism. The League for Human Rights of B'nai Brith Canada operates an anti-hate hotline, which receives complaints about antisemitic incidents, and publishes our *Annual Audit of Antisemitic Incidents*, the only report of its kind in Canada. I hope that all is well with you and your family during these unusual times.

We at B'nai Brith were surprised and disturbed to hear today of the College's proposal to ban male circumcisions, including for religious purposes, in any non-hospital setting. Please consider this letter to be B'nai Brith Canada's official feedback on this horrifying proposal, which would constitute a significant and unjustified impingement on Jewish Manitobans' right to religious freedom, and would potentially spark a legal challenge.

Firstly, we have serious misgivings with the way in which this potential change has been rolled out. We learned of the proposal just today from a Winnipeg *mohel,* i.e. a qualified performer of Jewish ritual circumcisions. Despite the obvious and serious effect this would on Manitoba's Jewish community, B'nai Brith was never consulted, and we understand that the Jewish Federation of Winnipeg was not either. This constitutes a serious breach of the College's duty to consult populations affected by its dictates, particularly religious minorities.

On a substantive level, any move to ban circumcisions outside of hospitals would have a significant and entirely negative impact on Jewish religious observance in Manitoba. For Jews, male circumcisions, typically performed on the eight day after an infant's birth, are a critically important lifecycle event, rather than a mere medical procedure. The family celebrating the circumcision will usually host a *seudat mitzvah*, or ritual meal, in their home or a local synagogue, immediately following the circumcision itself. Blessings are recited before, during and after the circumcision, often along with remarks by a rabbi or other religious official.

To state the obvious, Jewish circumcision rituals of this sort cannot properly be carried out in a hospital. Thus, requiring all circumcisions to take place in a hospital materially interferes with Jewish religious observance.

Tel: 1-844-218-BNAI | Anti-Hate Hotline: 1-800-892-BNAI
Email: league@bnaibrith.ca | www.bnaibrith.ca

League for Human Rights of B'nai Brith Canada
Ligue des droits de la personne

B'NAI BRITH OF CANADA LEAGUE FOR HUMAN RIGHTS
LIGUE DES DROITS DE LA PERSONNE

What makes this all the more bewildering is the apparent lack of any justification for taking this radical and unilateral step. We are not aware of any other Canadian provincial regulatory body – at least not in provinces with a significant Jewish population that bans circumcisions in any non-hospital setting.

Nor are we aware of any pressing medical or other public policy justification for this proposed change. In particular, we are not aware of any recent mishaps stemming from Jewish ritual circumcisions in homes or synagogues – not in Manitoba, or anywhere else in Canada, for that matter.

We are aware of other incidents, more broadly speaking, regarding ritual circumcisions in Manitoba. For example, we understand that a physician was disciplined by the College in 2018 with respect to certain Muslim ritual circumcisions that he had performed. However, the core issue in that case seems to have been practitioner (in)competence, rather than location, and at least some of those circumcisions were performed in a "Medical clinic" within the meaning of the new proposed Standard of Practice.

In fact, on that occasion, Dr. Ziomek told CBC that this was "the first instance of malpractice related to circumcision College of Physicians and Surgeons of Manitoba has dealt with in at least two decades." In other words, the proposed Standard of Practice appears to be a draconian "solution" in search of a problem.

Please let us know as soon as possible how the College intends to address this matter. **We fully expect the College to comply with its obligations under the *Charter of Rights and Freedoms* and rescind the proposed Standard of Practice, or amend it to exclude ritual male circumcisions.**

Sincerely,

Tel: 1-844-218-BNAI | Anti-Hate Hotline: 1-800-892-BNAI
Email: league@bnaibrith.ca | www.bnaibrith.ca

Jewish Federation OF WINNIPEG | THE **STRENGTH** OF A PEOPLE. THE **POWER** OF COMMUNITY.

July 13, 2021

Dr. Jacobi Elliott and Dr. Anna Ziomek
President and Registrar/CEO
The College of Physicians & Surgeons of Manitoba
1000-1661, Portage Avenue
Winnipeg, MB
R3J 3T7

Dear Dr. Elliot and Dr. Ziomek,

I am writing to you today on behalf of the Jewish Federation of Winnipeg, the representative body of Winnipeg's Jewish community, to voice our collective concerns with an aspect of the College of Physicians and Surgeons of Manitoba's Draft Standard of Practice for Performing Office-Based Procedures (including cosmetic/aesthetic and minor surgical procedures, platelet-rich plasma therapy, and laser service), which is in the public domain for consultation and feedback.

Included in this Standard of Practice are male circumcisions. In section 2.1 of the draft, it is noted *"members must not perform, or cause, permit, or enable another person to perform any procedure in a location other than a medical clinic."*

The performance of male circumcision by members (physicians) has been included in the draft, however, the performance of male circumcision as part of a brit milah, or part of a religious ceremony, was not explicitly referenced. If brought into force, this draft as it is currently worded would therefore make the performance of a Jewish brit milah by a physician outside of a medical clinic a violation of the College's Standard of Practice.

The brit milah has deep and fundamental roots in Jewish tradition and our heritage. Abraham was commanded by God to circumcise his son Isaac on the eighth day following birth. Since then, Jewish people have faithfully and continuously followed this commandment for thousands of years. A covenant between Jews and God, the brit milah is an indelible physical symbol of our everlasting bond with God. In addition, it is the rite of passage whereby our newborn sons are welcomed into the Jewish community, surrounded by the love of

their family and friends. This ceremony is often performed in a synagogue or a family home.

In addition, there is overwhelming evidence in peer-reviewed medical journals of the safety of circumcision and the skill of a trained and certified mohel (the person who performs the Jewish rite of circumcision). This literature review, by way of one of many examples, looked at almost 300 academic papers published in various medical journals and concludes that circumcisions are overwhelmingly safe, circumcision of infants at 8 days of age is the most advantageous time to undertake the procedure, and ritual Mohels uniquely qualified to perform them. Equally important, the arguments against circumcision are replete with factual errors, and apocryphal anecdotal evidence that does not survive critical review.

I urge you to consider the implications of this standard, which would infringe on our right to religious freedom, and amend the proposed Standard of Practice to explicitly exclude Jewish ritual male circumcisions.

Sincerely,

[redacted]
Jewish Federation of Winnipeg

Comment to the College of Physicians and Surgeons on the Proposed Practice Standard with respect to conducting certain procedures only in clinics

July 15, 2021

It was brought to my attention several days ago that the College is proposing a practice standard on performing office-based procedures. It would include circumcision as among the procedures that can only be done in a medical clinic.

The Jewish *brit milah* ceremony is an essential part of the faith and tradition and conducted on the eighth day after a boy is born. Manitoba legislation has determined if done for a religious or traditional purpose, it is not an act that can only be lawfully done by a physician. That provision remains in force. Accordingly, if I understand correctly, under the proposed practice standard a non-physician *mohel* – an expert in conducting the *brit milah* ceremony -would still be able to carry out the procedure in a baby's home or in a synagogue. But if the *mohel* is also a physician the proposed practice standard would require that the procedure be carried out only in a medical clinic.

The consequence of the proposed practice standard would be to impair or effectively deny the ability of Jewish parents to practice an essential tenet of their faith and tradition.

To begin with, it may be difficult or impossible to obtain the services of a non-physician *mohel* for a home *brit milah.* My understanding is that in Manitoba currently almost all *brit milot* are done by a physician *mohel. Excluding physician mohels from conducting a home brit milah has the potential to have a devastating impact of the ability of Jewish families in Manitoba to live in accordance with a bedrock element of their beliefs, tradition and collective identity.*

A physician *mohel* might not be available or willing to conduct the *brit milah* in a clinic. The family might, reasonably find the alternative unacceptable even if offered. Among other considerations:

- There might not be room available for parents or other family and friends in the waiting area where the procedure is done. A *brit milah* is an event that, by faith and tradition, is supposed to involve family and the faith community; https://www.myjewishlearning.com/article/why-the-minyan-community-and-brit-milah/

- The *brit milah* participants might wish, out of concern for privacy or even safety given the rising level of antisemitism in our society, to have the ceremony in a space where the attendees are known and trusted;

- From the point of view of overall medical safety, including preventing the spread of infections, conducting a *brit milah* at a clinic might be unacceptable to the physician, the *brit milah* participants or other patients. It would bring people to the clinic who are not in need of medical diagnosis or treatment. It would expose

> the *brit milah* participants to an environment that are attended by many persons who are seeking help with infectious diseases, increasing the net risk of carrying out a *brit milah*. It would involve transporting a newborn – sometimes in dangerously cold weather or bad driving conditions- to a clinic. The newborn might have to wait there for hours with disruption to the child's feeding and comfort – if the physician is backed up or called away on an emergency.

As the College no doubt appreciates, it is not necessarily safer to conduct a procedure in a clinic or hospital. Much depends on the nature of the procedure and the different kinds of expert support available in different environments. Extensive studies of deliveries have found that in low-risk pregnancies, for example, it is just as safe to have a midwife assist in the delivery at the family home.

If the clinic *brit milah* alternative is unavailable or, with good reason, unacceptable to Jewish parents, a family might find there is simply no non physician *mohel* available to carry out the procedure and ceremony at home.

Even if a non-physician *mohel* is available, that might not be the preferred choice for a family from a medical safety point of view. Non-physicians *mohels*, as I understand it, have an excellent record of safety; indeed, some non-Jewish parents in some jurisdictions prefer to have them conduct circumcisions on their newborns. But a physician *mohel* has an extra dimension of training. Furthermore, in a place like Manitoba, a physician *mohel* is likely to be the most experienced person available to conduct the procedure, and with respect to medical procedures generally, studies have found that extensive experience is strongly correlated with efficacy and safety.

Given the potential impact on the viability of Jewish families to maintain their faith and way of life, the College is required by overriding human rights law to consider the specifics of the *brit milah* and calibrate carefully any limitations that might affect how it is performed. This means there is a need to consult with the Jewish community, gather evidence, consider the benefit and risks of various alternative regulatory approaches, and fine-tune any regulations in a way that minimizes or removes the harm to freedom of religion in the course of addressing safety concerns.

The consultation documents I can find on the College's website do not provide the specifics of whatever information or analysis the College has done so far in developing the proposed standard generally. The proposed standard is broad in its sweep, and it might be the case that the College has not yet conducted a focused analysis on the particular legal and medical dimensions of the *brit milah* tradition. In any event, this consultation provides the College an opportunity to now do so, or to do so in greater depth and with the benefit of extensive community consultation.

Human rights law requires the reasonable accommodation of religious belief and practice.

In this case, from the information of which I am aware so far, there does not appear to actually be any trade-off required between religious freedom and legitimate goals such as patient safety.

When I look at the disciplinary records of the College at its online site, the only issues that have arisen with physician-conducted circumcisions in modern times appear to have been in respect of procedures that took place in a hospital or clinic The kinds of errors involved there might actually be avoided where the procedure is conducted at home. The home ***brit milah*** is a context in which there is ample opportunity for the physician ***mohel*** to consult with the family and be assured that the choice to proceed is entirely free and informed.

As already mentioned, the clinic or hospital alternative may have its own distinct risks in addition to confusion or limited consultation that can take place in a busy, multiclient and multitasking institutional environment. With respect to the baby they include potentially transporting it in uncomfortable or dangerous conditions, protracting the time frame in which the baby is removed from its routine, and exposing it to an environment where strangers may be seeking or obtaining treatment for contagious diseases.

Again, denying the ability of physician ***mohels*** to conduct a home ***brit milah*** may mean <u>that the most experienced and medically expert individual is not available to a family</u>.

The Manitoba government has already, in its regulations, recognized the distinctive nature of the ***brit milah***. Whatever the broader merits of the proposed standard, there appears to be a clear case for providing that the "only in a clinic" requirement should <u>not</u> be extended to physician ***mohels***. As noted at the outset of this comment, Manitoba legislation already recognizes the distinct nature of male circumcisions carried out "in the course of a religious ceremony or tradition"; please see The Regulated Health Professions General Regulation, s. 4. The proposed practice standard could incorporate that statutory language in defining the exemption from the proposed practice standard.

Sincerely,

[redacted]

Complications of Circumcision in Israel: A One Year Multicenter Survey

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Key words: circumcision, complications, bleeding

Abstract

Background: In Israel, virtually all children undergo circumcision in the neonatal period. Traditionally, it is commonly performed by a "Mohel" (ritual circumciser) but lately there is an increasing tendency among the educated secular population to prefer a medical procedure performed by a physician and with local anesthetic injection.

Objectives: To evaluate the outcome of this procedure and to compare the complication rate following circumcisions performed by ritual circumcisers and by physicians.

Methods: In 2001, of the 19,478 males born in four major medical centers in Israel 66 had circumcision-related complications. All the children were circumcised in non-medical settings within the community. The patients were medically evaluated either urgently due to immediate complications or electively in outpatient clinics later on. Upon the initial assessment a detailed questionnaire was filled to obtain data regarding the procedure, the performer, and the subsequent complications.

Results: All the circumcisions were performed during the early neonatal period, usually on day 8 of life (according to Jewish law). In 55 cases (83%) it was part of a ritual ceremony conducted by a ritual circumciser (Mohel), while in 11 babies (17%) physicians were involved. Acute bleeding after circumcision was encountered in 16 cases (24%), which required suturing in 8. In addition, we found two cases of wound infection and one case of partial amputation of glans penis in which the circumcision was performed by a ritual circumciser. Among the late complications, the most common was excess of skin in 38 cases (57%); 5 children (7.5%) had penile torsion and 4 children (6%) had shortages of skin, phimosis and inclusion cyst. The overall estimated complication rate of circumcision was 0.34%.

Conclusions: Complications of circumcision are rare in Israel and in most cases are mild and correctable. There appears to be no significant difference in the type of complications between medical and ritual circumcisions.

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Circumcision is the most common surgical intervention performed in non-medical settings within the community and is performed on millions of male children worldwide. Neonatal circumcision continues to be a controversial issue, although it has been shown to have a preventive effect on urinary tract infections in infants and penile cancer that might develop later in life. Some concerns include reduced sensation of the penis and sexual pleasure, as well as possible complications associated with the procedure itself. There is usually no medical indication for circumcision, and its performance is motivated by religious, cultural or aesthetic reasons among Jews, Moslems, Africans, and native Australians as well as many Christian Americans [1,2]. According to the U.S. National Center of Health Statistics [3], 61% of boys born in the United States in 1987 were circumcised. The procedure is less commonly performed in other countries, mainly northern Europe, Central and South America, and Asia. About 48% of males are circumcised in Canada and only 24% in Britain [4].

Circumcision has been part of Judaism from the very beginnings of the religion, when it was performed by Abraham, following God's instruction, on his sons Isaac and Ishmael, as well as on himself. The Jewish method of circumcision has been performed for thousands of years and has been passed on from generation to generation. The procedure is usually carried out by non-medical practitioners, and the technique has remained virtually unchanged over the years. Israeli males are circumcised in the neonatal period. Traditionally, it is performed by a "Mohel" (a ritual circumciser), but today there is an increasing tendency among the educated secular population to prefer a medical procedure performed by a physician using local anesthetic injection.

Although pediatric urologists are primarily involved in the procedure only in the minority of newborns, they serve as the ultimate referral physicians in all cases of circumcision-related complications. The pediatric urologist would usually encounter those cases in the emergency room setting or in outpatient clinics. The training and supervision of the *mohelim* (ritual circumcisers) in Israel is the responsibility of the Ministry of Religion and the Ministry of Health. Certification is granted following a special training course that includes lectures and examinations, and minimal experience. However, this training is not mandatory by law and many *mohelim* are not certified. Non-medically trained *mohelim* perform the vast majority of circumcisions. In this report of our multicenter prospective study we describe the complications resulting from circumcision.

Patients and Methods

This prospective study was conducted during 2001 in four major tertiary care medical centers in Israel. Of the 19,478 male infants born in these institutions, 66 had circumcision-related complications, yielding an estimated complication rate of about 0.34%.

The patients were assessed either urgently after the procedure due to immediate complications, or electively in the outpatient clinics later on. Upon the initial assessment, a detailed questionnaire was obtained by the pediatric urologist, and data on the patient, the procedure, the performer and the subsequent complications were collected. The complications were defined as either immediate (bleeding, infection or penile injury), or late sequelae (excessive foreskin, penile curvature, penile torsion, shortage of skin, phimosis and inclusion cysts). Inclusion cyst was defined as a sub-cuticular mass on the penile skin that resulted from buried skin containing dead skin cells. Excessive foreskin was defined as the extent to which it covered at least half of the glans penis. In cases of children with excessive pre-pubic fat the evaluation of the extra skin was done while applying pressure on the fat at the base of the penis towards the pubic bone. Penile torsion was considered a complication only if the angle of the rotation exceeded 30 degrees. Meatal stenosis, a condition commonly regarded as an associated late complication of circumcision and usually diagnosed at the age of toilet training, was not included in this series.

Results

All 66 circumcisions in this study were performed during the early neonatal period, usually on day 8 after birth, according to Jewish law. The circumcision was in the setting of a ritual ceremony conducted by a ritual circumciser (Mohel) in 55 (83%) male infants, while physicians performed the procedure in the remaining 11 (17%).

Excessive bleeding after circumcision was encountered in 16 infants (24%). Suturing was used to stop the bleeding in eight infants, and conservative treatment including local pressure and dressing was used in the other eight. There was no case of hemorrhage requiring blood transfusion. Noteworthy, in 14 of the 16 cases of bleeding (87%) the circumcision was performed by ritual circumcisers, while in 2 (13%) it was performed by physicians. In addition, two patients with wound infection and one patient with partial amputation of distal glans penis were circumcised by ritual circumcisers.

Excessive foreskin was the most common late complication (38 cases, 57%). Five children (7.5%) had penile torsion and 4 children (6%) had shortages of skin, phimosis, and inclusion cyst. All these late complications were successfully treated by elective surgical repair with the child under general anesthesia.

Discussion

In Israel, neonatal circumcision is commonly performed by a "Mohel" when the male infant is 8 days old; this ritual event usually takes place in a celebration hall in front of an audience of family and friends. The conditions are usually clean but not sterile, and anesthesia is not used. Clearly, these are not optimal conditions for such a delicate procedure in neonates. The procedure should be done quickly and smoothly, by means of a technique that involves detachment of the foreskin from the glans penis and cutting both the inner and outer prepuce in one incision without suturing, leaving the penis to heal secondarily. Therefore, the Israel Ministry of Health supervises the training of the "Mohelim," and they should follow strict regulations. In recent years however, there is an increased demand among the non-religious population in Israel for a medical circumcision to ensure improved sterility conditions and local anesthetic injection. Interestingly, the medical circumcisions are often performed by obstetricians, neonatologists, pediatricians, general practitioners, general surgeons, etc., and only rarely by urologists. With no solid data for comparing the outcome of religious versus medical circumcisions, the preference of either a physician or a Mohel is usually influenced by other considerations such as religious background, tradition, common knowledge, and recommendations.

In several large series of newborn circumcisions (combining ritual and medical), the complication rate ranged from 0.2% to 0.6% [5,6]. The early complications included mainly bleeding, which was reported in 0.1–35% [7], and wound infection in 0.2–0.4% [5,8]. Relatively rare are urinary retention caused by an excessively tight circular bandage [9] and penile or urethral injury [10], while meatitis is a frequent complication of circumcision with a reported incidence of 8–31% [11,12]. In such cases, the newborns are generally referred urgently to the urologist and are examined in the emergency room.

For most late complications the affected babies are electively examined by urologists in outpatient clinics due to either parental or primary care physician dissatisfaction. Parents generally claim that the child does not look circumcised or that the penis "does not look right." Most of these cases represent a minor cosmetic abnormality that requires no more than reassurance. Not infrequent, however, are late complications resulting from a technically inadequate circumcision; these include excessive foreskin, shortage of penile skin, penile torsion, penile curvature, formation of inclusion cysts of the penile skin, phimosis, mature scarred skin bridges, lymphedema, urethral fistula, and meatal stenosis. These complications usually produce what is essentially a cosmetic and not a functional problem. The urologist is often faced with the dilemma of whether the complication is significant enough to justify surgical circumcision repair under general anesthesia.

Our estimated complication rate of 0.34% is quite low and similar to the estimated figures of 0.2–0.6% reported in the literature [2]. The possible explanation for this low complication rate is probably under-reporting, since many of the complications are quite minor and do not require surgical repair, while others are diagnosed later and are mistakenly not attributed to the circumcision. This may be especially true for penile curvature and meatal stenosis, the latter of which was not included in that study.

In the present study, the overall circumcision-related complications appear to be rare. In accordance with the literature, the most common complication in the current series was excess of skin in 38 cases (57%). Overall, the estimated incidence rate of this complication is 1%–9.5% [4,13] and the wide range of the reported rates can understandably be related

to the subjective interpretation of this finding. Therefore, we considered the foreskin to be excessive only if the skin covered more than 50% of the surface of the glans penis and only then did we recommend surgical repair. When there is a significant excessive foreskin after circumcision, the parents are sometimes told that the redundant skin will disappear as the penis grows. This is incorrect since the penis and the foreskin grow in parallel and there is no improvement in the appearance of redundant foreskin with age [14]. However, when there is some excess of skin associated with "buried penis" due to a deep pre-pubic fat pad, improvement can be expected with the child's growth and attendant reduction of the pre-pubic fat pad. The 0.01% infection rate is very low in this series, most likely due to the excellent healing capability and rich blood supply of the penis in the newborn. There was only one case of a major complication in our series (partial amputation of glans penis) and it resulted from a circumcision performed by a ritual circumciser.

Overall, the type of complications following circumcision performed by ritual circumcisers and physicians were similar. We presume that this finding reflects the low rate of circumcision-related complications in Israel. We attribute this low rate to the fact that usually, circumcision is the sole or main occupation of the *mohelim* and, therefore, most are professional and experienced. In addition, they usually work under strict regulations; being concerned about malpractice claims, they are obliged to adhere to high standards of performance.

In conclusion, complications of circumcision are rare, mild, and correctable in the vast majority of cases. There appears to be no signifcant difference in the type of complications between medical and ritual circumcisions.

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I'm not offended by all the dumb blonde jokes because I know I'm not dumb – and I'm also not blonde.

Dolly Parton

Standard of Practice
Performing Office Based Procedures
Including Cosmetic/Aesthetic and Minor Surgical Procedures, Platelet Rich Plasma Therapy, and Laser Devices)

Initial Approval: **Effective Date:**

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

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

PREAMBLE

The College of Physicians and Surgeons of Manitoba sets standards that establish expectations for quality care for patients regardless of whether the care provided is medically required or purely elective. Many members perform various in-office procedures on their patients that are medically required or elective. Some of this care is provided in non-hospital medical or surgical facilities and is therefore governed by the Accredited Facilities Bylaw. However, many procedures are performed in non-institutional settings such as established physician offices or medical clinics. When providing this care, members must comply with this Standard.

Medical clinic is defined as a medical care facility that is primarily focussed on providing outpatient medical care by CPSM members and includes what is commonly known as a physician's office. It does not include a non-medical aesthetic clinic, medi-spa, lash bar, residence, or hospitality facility. It does not include a home office.

APPLICATION

1. This Standard applies to insured and non-insured procedures that are reserved acts under the RHPA performed by a CPSM member.[1] These procedures (referred to as "**procedures**") include:
    a. Vasectomy;
    b. Male circumcision, excluding neonatal; (for female see Standard of Practice Female Genital Cutting/Mutilation prohibiting female genital cutting/mutilation)
    c. Cosmetic/aesthetic procedures which may include, but are not limited to:

[1] This Standard only applies to CPSM practitioners. It does not apply to other people who perform any of these listed procedures

1. Application of laser energy and light-based therapies for the removal or ablation of skin lesions and pigmentation; (See Appendix 3)
2. Soft tissue augmentation – injections of fillers; (See Appendix 1)
3. Botulinum toxin/Neuromodulators - injectable (See Appendix 1)

d. Procedures aimed at the treatment of known pathology may include, but are not limited to:
   1. Peripheral stem cell injection as approved by Health Canada; and
   2. Platelet rich plasma injection as approved by Health Canada; (See Appendix 2)

2. This Standard also applies to procedures performed in any location including an Accredited Facility Accredited Facilities Bylaw.

3. This Standard does NOT apply to:
   a. procedures performed in a hospital or government owned or operated hospital or healthcare facility.
   b. office-based ophthalmic procedures.
   c. Acts that are not reserved acts under the RHPA (examples include facials, peels, microdermabrasion, micro-needling, and laser hair removal).

1. Knowledge, Skill, and Judgment

1.1. Members must work only within the limits of their competence and scope of practice and refer a patient to another practitioner if they cannot safely meet the patient's needs.
1.2. If the procedure to be performed was not part of the member's medical or specialty education and training, before carrying out the procedure for the first time, members must ensure they have the necessary knowledge, skill, and judgment to do so. Members must ensure they can: recognize when patients are not suitable to undergo the procedure, safely perform the procedure, and manage potential complications, by undergoing significant training and/or seeking opportunities for supervised practice.
1.3. Competence must be maintained.
1.4. Members must practise evidence-informed medicine and maintain a level of understanding of the available evidence supporting the procedure as it evolves.

2. Safety and Quality of Care

2.1. Members must not perform, or cause, permit, or enable another person to perform, any procedure in a location other than in a medical clinic.
2.2. Members must only perform procedures in a medical clinic that is safe, appropriate, and sanitary, is suitably equipped and staffed, and complies with any relevant regulatory requirements, and the Infection Prevention and Control for Clinical Office Practice.

2.3. Each member must take reasonable steps to ensure a system is in place for the proper maintenance, cleaning and calibration of equipment used in the medical care they provide.
2.4. Members must also comply with the Practice Environment Standard of Practice.
2.5. Members must ensure that the medical clinic has the capability to provide at a minimum, Basic Life Support including appropriate training and certification for staff.
2.6. Members must be open and honest with patients in their care and disclose if there is an adverse patient outcome. Members must comply with the CPSM Standard of Practice Good Medical Care *(**Section 9. Disclosure of Harm to a Patient**)*. In the event of an adverse patient outcome, the member performing, authorizing, or most responsible for the procedure must ensure a care plan is established to mitigate the effects in a satisfactory manner.
2.7. The medical director of the clinic must notify the Assistant Registrar of Quality within one working day of becoming aware of a patient with an **adverse patient outcome** and provide a written report within two weeks.
2.8. An **adverse patient outcome** is defined as an unanticipated significant outcome, either by misadventure, complication, or patient reaction that requires higher level care by an alternate CPSM member and includes but is not limited to:
    2.8.1. Transfer to hospital or unanticipated follow-up at a hospital related to how the procedure was performed or how the patient responded to the procedure;
    2.8.2. Third degree burns, disfigurement, or impairment of vision;
    2.8.3. Extreme pain or discomfort causing significant limited function in an ongoing fashion;
    2.8.4. Intra-arterial injection resulting in thrombosis, tissue ischemia, necrosis, or embolism with risk of blindness;
    2.8.5. Injecting or infusing the wrong material than originally intended.

3. Seeking Patients' Consent

3.1. Members must comply with the CPSM Standard of Practice Good Medical Care *(**section 5. Informed Consent**)*. Consent must be obtained in writing. Members must exercise additional scrutiny and caution when considering requests for procedures on minors or those with reduced capacity.
3.2. Members must consider the patient's psychological needs and whether referral to another member or regulated health professional is appropriate (i.e. body dysmorphic disorder).

4. Practice Management of Procedures Provided by Non-CPSM Members

4.1. There must be a member identified as most responsible for care for every procedure performed in a medical clinic.

4.2. Members most responsible for care or their delegate must assess the indications and potential contraindications for each patient and must personally assess each patient undergoing an invasive procedure.

4.3. The member most responsible for care must be available to attend at the same location as the procedure is performed should circumstances arise where they are required to assist non-CPSM member providers or to manage misadventure or complications arising from the procedure. "Available to attend" means that in the event of an urgent or semi-urgent episode or complication that exposes the patient to increased risk of harm, the member most responsible for care must be available to attend within a reasonable time consistent with the nature of the episode or complication.

4.4. Members must ensure that anyone participating in the patient's care has the necessary knowledge, skill, judgment, training, and competence and is appropriately supervised. Members may delegate to non-CPSM member providers to perform any procedure in an accredited facility, if the delegation is specific and supervised and under the direction of that physician. This does not apply to regulated health professionals under the *Regulated Health Professions Act* acting within their own scope of practice (i.e. Nurses). (See Contextual Information and Resources).

5. Obligations of Medical Director

5.1. The medical director is responsible for all aspects of the medical clinic which can affect the quality of patient care and is responsible to ensure:

5.1.1. the enforcement of this Standard and appropriate standards of care, including the safe, effective, and good medical care of patients in the medical clinic;

5.1.2. adequate quality assurance and improvement programs, including the monitoring of infection and medical complications, are in place;

5.1.3. a procedures manual is available and maintained for guidance;

5.1.4. if procedures are performed at the medical clinic that carry a risk of cardiac arrest or allergic reaction, ensure the availability of appropriate resuscitation equipment and medications and the presence of staff who are appropriately trained to utilize the equipment and medications;

5.1.5. a policy is in place for emergent complications, including but not limited to anaphylaxis, allergic reaction or acute embolic event, and the authorized non-physician providers present must be appropriately trained to recognize emergent complications;

5.1.6. that all medical devices, equipment, drugs, and other substances utilized in medical care are Health Canada, CSA, or FDA approved.

5.2. The medical director must be in attendance in-person at the medical clinic for sufficient time to ensure that all their obligations are discharged satisfactorily to ensure patient safety.

5.3. The medical director must ensure that the medical clinic, or members or other persons performing procedures do not function to increase profit at the expense of good medical care.

5.4. Members must only be medical directors of medical clinics in which they actively practice. Members must not be medical directors of non-medical clinics or other entities.

6. Liability coverage

6.1. Any member performing procedures or who is involved in authorizing non-CPSM member providers to provide or assist in procedures must ensure they have appropriate professional liability protection.

7. Communicating Information about Procedures Offered

7.1. When advertising or promoting procedures, including through the use of social media, members must follow the applicable provisions in the Standard of Practice Advertising, Standard of Practice Conflict of Interest, and the Code of Ethics and Professionalism.
7.2. Members must ensure information being communicated is responsible, factual, does not exploit patients' vulnerability or lack of medical knowledge, is not capable of misleading or misinforming the public, and does not minimise or trivialize the risks of procedures or claim that procedures are risk free.
7.3. Members must not mislead about the likely results of a procedure. They must not falsely claim or imply that certain results are guaranteed from a procedure.

8. Honesty in Financial Dealings

8.1. Members offering procedures must be open and honest with patients about financial or commercial interests that could be seen to affect the way they care for patients.
8.2. Members must not allow financial or commercial interests to affect good medical care.
8.3. Members must be comply with the Standard of Practice on Conflict of Interest and Code of Ethics and Professionalism.

APPENDIX 1 – INJECTION OF FILLERS – SOFT TISSUE AUGMENTATION AND BOTULINUM TOXIN/ NEUROMODULATORS

1. In addition to complying with the above Standard of Practice requirements, members who provide, authorize, delegate, or enable injections of botulinum toxin, dermal fillers, fillers of any sort injected below the dermis, or neuromodulators, controlled products, of other injectable cosmetic substances (all defined as substances) must comply with this Appendix.
2. Members must ensure only substances approved by Health Canada are injected.

3. Members who inject substances must have completed relevant and significant procedure specific medical education and training prior to performing such procedures.
4. Members must not themselves, nor may they permit or enable any other person to inject these substances in a location other than their medical clinic and then only as part of good medical care.
5. Members may permit a regulated health professional acting within their scope of practice to inject these substances in their medical clinic. Members must not permit or enable any other persons to inject these substances.
6. Members must not authorize the purchase, distribution, or dispensing of these substances, for use by other persons outside their medical clinic, whether regulated health professionals or not.
7. Members must perform an assessment and provide a client specific order for *Schedule 1 drugs under the Controlled Drugs and Substances Act* when collaborating with a regulated health care professional to administer the drug where that regulated health care professional is not authorized to prescribe.
8. Members must have appropriate antidotes present when performing these injections.

APPENDIX 2 – PERFORMANCE OF AUTOLOGOUS PLATELET RICH PLASMA THERAPY

Platelet rich plasma (PRP) therapy is based on the theory that the use of patient's own blood factors may improve tissue repair and healing. The validity of any potential beneficial effects of RPR therapy continues to undergo further definition and evaluation. This also includes the variability with: technique, number and spacing of injections, number/concentration/exogenous activation of platelets, with/without leukocytes and a definition of the appropriate candidate.

1. The PRP procedure involves multiple steps requiring handling blood products. Members must pay special attention to maintaining the sterility of technique and product to ensure patient safety. The risk of contamination reflects the number of steps within the PRP procedure. Contamination can easily occur during venipuncture, selection/handling of collection devices, separation containers, multiple centrifugation runs to isolate the PRP layer and the injection of the concentrated aliquot. Members must ensure the critical ability to perform all steps of the PRP procedures without contamination due to the inability to filter-sterilize the end product prior to injection. The entire procedure must take place at one patient visit.
2. Members must ensure compliance with the Standard of Practice Good Medical Care. ***(Section 11. Non-Traditional Therapies)***
3. Members who offer and perform platelet rich plasma services must comply with the College of Physicians and Surgeons of Alberta's Guideline "Performance of Autologous Platelet Rich Plasma Therapy in Unaccredited Settings: A Guideline for Physician Office/Clinic Setting".

APPENDIX 3 – LASER SAFETY

1. In addition to complying with the above Standard of Practice requirements, members who use a laser device for patient care and/or treatment must comply with this Appendix.
2. Members who use a laser device for patient care and/or treatment must have completed relevant and significant specific laser operation education and training prior to performing procedures with a laser.
3. Members must ensure that unregulated health care workers or technicians applying laser in their clinics have documented relevant and significant specific training and possess the requisite knowledge, skill and competence to safely perform the laser procedure. Members must define the degree of medical supervision required and must perform, at a minimum, annual competency assessments of each individual performing laser treatments that include observed procedures with feedback and must maintain a record of those assessments.
4. Members utilizing regulated health professionals who require additional education to authorize performance of the reserved act must ensure the additional education received meets requirements as outlined by that regulated health professional's College.
5. Members must use lasers in compliance with existing standards and occupational health and safety regulations and must keep current with the standards as they are updated from time to time. Members must refer to CSA Z386-2014 *Safe Use of lasers in health care*, and ANSI Z136.3-2018 *Safe use of lasers in health care*, and both are current at the time of this standard in 2021.
6. In addition to the above-mentioned standards, members must comply with CPSBC's CPSBC's Practice Direction on Laser Safety for Physician Practice and the CPSBC's Laser Safety for Member Practice Summary.

DECEMBER COUNCIL MEETING
DECEMBER 8, 2021
BRIEFING NOTE

TITLE: Complaints and Investigations Restructuring Proposal

BACKGROUND

CPSM Complaints and Investigations

Council is asked to consider approving a new Complaints and Investigation Practice Direction, circulated as a separate document. This briefing explains the relevant background and goals of the Complaints and Investigation Committees, as administered through staff in the Complaints and Investigation Department.

What we do matters.

CPSM is mandated to regulate the practice of medicine and govern its members in accordance with the RHPA and its regulations, the by-laws, Standards of Practice of Medicine, practice directions, and the Code of Ethics. A robust process designed to address concerns raised about the care and conduct of members, whether by a complaint from a patient or information reported by a colleague or health care institution, is an essential component of effective regulation.

Our goals in the process are:

- To be fair and consistent
- To listen to all perspectives
- To balance efficiency with a thorough and detailed review
- To balance transparency with privacy
- To encourage and assist with conflict resolution
- To improve care and conduct where possible through feedback and/or remediation
- To discipline where appropriate and in the public interest
- To increase trust in the profession

How we do it matters.

It is important that our complaints process be structured such that it promotes participation from the public and respects CPSM members. Effectively addressing legitimate concerns about our members helps CPSM ensure that high professional standards in the profession are maintained. Lack of confidence in the system may discourage complainants from coming forward, which undermines CPSM's core public interest mandate.

Most concerns arise from a patient complaint about a member. For both parties, the complaints process can be daunting. The process should be no more intrusive than necessary while at the same time being diligent and focused on the public interest. Preconceived notions about CPSM's role can have a negative impact and the stakes are high.

Traditionally, individuals involved in our process write a letter of complaint, receive the physician's reply to the concerns, and provide their further written comments about that reply. After the Committee has met and discussed the matter, the complainant receives a letter of decision. Some changes have been made over time to increase complainant input, including meeting with complainants where appropriate.

The following section references an Australian study titled, *How Can We Make Health Regulation More Humane? A Quality Improvement Approach to Understanding Complainant and Practitioner Experiences* by Susan Biggar, Louisa Lobigs, and Martin Fletcher in the Journal of Medical Regulation (2020, 106 (1) 7-15) **https://doi.org/10.30770/2572-1852-106.1.7**

This study examined complainant and practitioner feedback where they were involved in the regulatory authority complaints process. The authors noted that addressing complaints plays a central role in Medical Regulatory Authorities' ("MRA") patient safety mandate, and it is important to understand the various perspectives.

In 2017 – 18 the authors conducted a survey of 1217 complainants and 1604 practitioners in Australia, of which 50% were physicians, 19% were nurses and the remainder were other health care practitioners. This study is relevant to CPSM as our process appears to be very similar, with written exchanges being the primary form of communication.

Complainants submitted information and eventually received a written decision. Important findings included:

> *Respondents in both groups felt the process was not fair or impartial, and lacked transparency and adequate updates. The time taken to reach an outcome was a frustration for many (complainants 46%, practitioners 49%). A notable difference between the groups was their view of the outcome: 70% of practitioners were satisfied and 71% of complainants dissatisfied. Finally, many practitioners (89%) reported high levels of stress.*
>
> *Designing regulatory processes that are robust and humane is complex and multifaceted. However, the symmetry of priorities for both parties identified — fairness, transparency, communication, timeliness and empathic contact — highlights the value of understanding both complainant and practitioner experiences. This knowledge can lead to improvements in the trustworthiness and effectiveness of health-practitioner regulation, and its contribution to patient safety.*

The authors emphasized that there can be unintended harm to both complainants and practitioners:

> *Studies have shown physicians subject to a notification* (complaint) *were at higher risk of suicidal thoughts, anxiety and depression compared to their peers, reporting anger, guilt, depression and shame following a notification. These studies reported practitioners practicing defensively, becoming overcautious and avoiding more complex patients, with reduced trust and less goodwill towards patients.*

Some of the positive aspects identified were that complainants and practitioners felt it was easy to submit information, and in general felt they were given adequate opportunity to respond. Complainants were particularly happy about phone discussions with staff.

Complainants were dissatisfied with the overall management of their complaint (66%) and the outcome (71%). Open ended responses showed dissatisfaction with fairness, communication, decision, and timeliness. Comments included that they didn't feel heard, they had no opportunity to challenge the outcome, they didn't understand the process or the outcome, and it took too long.

Practitioners too did not feel they had adequate updates on the progress of their matter. The themes of their concerns were regarding timeliness, stress, fairness, and communication. Comments included that the complaint was not put into context, wasn't considered by a clinical expert, or dealt with a minor issue such that it was "a waste of time". They expressed concern that they were "guilty until proven innocent" and this impacted their health and well-being. They felt the process took too long and unfairly prolonged their stress. More practitioners (70%) than complainants were satisfied with the eventual outcome.

A 2019 Canadian Medical Association Journal article (CMAJ May 06, 2019 191 (18) E505; DOI: by Joy Albuquerque and Sarah Tulk) https://doi.org/10.1503/cmaj.181687 reports that compared with non-physicians, male physicians are 40% more likely to die by suicide and female physicians have a rate more than double female non-physicians. This difference begins in medical school. A study out of the UK noted that those with a recent or current regulatory complaint were significantly more likely to report suicidal ideation.

The Australian study concluded that there are some important considerations for change, and CPSM has considered these in our context.

1. The nature of the desired experience for complainants and practitioners should be clearly defined. The main MRA responsible for the study described a "good experience" to be one that included respect, listening, transparency, updating, timeliness, apology, improvement, and fairness.

CPSM is committed to these same principles. We seek to balance efficiency with thoroughness, and our mandate of public protection with respect and fairness to members.

We recognize that bringing a complaint forward can be stressful. The process can be especially difficult for complainants who have experienced grief or trauma. Responding to a complaint is also stressful. Physicians are reminded of the resources offered by Doctors Manitoba to address stress where our process is anticipated to be particularly difficult or lengthy.

2. Set clear expectations from the start.

CPSM asks about expectations on the complaint form and tries to address any unrealistic or impossible expectations at the outset. Admittedly, less attention is given to identifying the expectations of physicians, though they are usually represented by legal counsel with significant experience in our system and we always encourage and facilitate consultation with legal counsel, which is usually covered by CMPA or insurers of those who are not members of CMPA. We also direct both complainants and members to our website information and encourage contacting staff in our department by telephone or email if they have questions.

3. Ensure fair and impartial processes and communicate these processes well. They noted that written exchanges can be dehumanizing. The importance of training staff to actively listen, communicate effectively and recognize and respond to people in distress were highlighted.

At CPSM there are currently two staff members who answer calls to our Complaints and Investigation Department - one is a social worker and the other has years of experience. Both are exceedingly patient and helpful to callers, answering all manner of questions, including those related to complaints and how to get started. They direct callers to appropriate resources including information about Standards of Practice.

In August 2020 we added a social worker to work as a Public Support Advisor and she is dedicated to assisting complainants through our process. She tries to contact everyone who has submitted a complaint, lets them know where it is in the process and often spends significant amounts of time listening to people tell their stories. Her job is not to counsel, but she has provided information about additional resources where applicable and allowed people to be heard rather than just writing a letter and waiting for a conclusion. She also provides support to witnesses in Inquiry hearings.

4. Improved communication.

The study noted the value of improving the tone and clarity of correspondence. One thing particularly noted was that complainants place a high value on clear and fulsome reasons for any decision made about the outcome of their complaint.

CPSM's Complaints and Investigation Department is continually trying to improve letters and website explanations. We have received feedback that Complaints Committee decisions were particularly lacking in rationale for the decision. Significant changes have been made to the form and content of Complaints Committee decisions in response to this feedback. At the Investigation Committee level, we are faced with the difficult challenge of communicating decisions that are both legal documents with precedent value on the one hand while writing to a member of the public who may not have sophisticated English skill on the other.

Other Challenges:

Underlying each complaint is an experience that did not meet an individual's expectation. The task for the Complaints and Investigation Committees is to carefully review each person's perspective and determine if professional standards were reasonably met, and what, if anything, is needed to address any deficiencies. The nature of an unresolved concern that has come to the CPSM in the form of a complaint is such that neither party will be completely satisfied with the outcome, including where we are able to resolve a matter with a mediated/facilitated outcome, because compromise is usually involved. . Feedback from complainants include that CPSM is "protecting" doctors. We recognize that the event that led to the complaint has often led to distrust, and where our process does not validate their concerns, it can cause further distrust in the profession. The best explained and well-reasoned Notice of Decision may not satisfy someone who is grieving, angry, hurt or experiencing mental health challenges.

We recognize that the vast majority of practitioners are doing the best they can. Some may have difficulty acknowledging deficiencies in their care or conduct. Many choose to end a patient-physician relationship when a complaint is launched against them rather than try to work through the conflict and resolve it. The complexities of making clinical decisions about a patient in the midst of emotional tension within the professional relationship is acknowledged. Physicians may overcompensate or second guess their decisions. While there are professional expectations that physicians acknowledge where harm has been done, apologize where applicable and establish a plan to address it, there are often personal and cultural expectations that may make this difficult.

Physicians can see our process as adversarial. Clear messages about a renewed focus on humility and ensuring members and their legal counsel are reassured about the goals of the complaints process are important moving forward.

Our Current Process

Under the previous legislation (*The Medical Act*) two levels of committee were established whereby the Complaints Committee (CC) resolved matters on an informal basis. Traditionally CPSM did not include these matters on a Certificate of Professional Conduct. The Investigation Committee (IC) heard more serious matters because of their additional powers to compel information and pursue

measures to improve care, such as voluntary undertakings for remediation or conditions/restrictions on a practice. The distinctions were logical such that progressive actions flowed. That said, the ability of complainants to ask for referral of their complaint to the IC where they were unhappy with the outcome from the CC rendered the distinctions moot in many instances. This is because many cases were referred to the IC based purely on a complainant being dissatisfied with the CC's decision and were not necessarily sufficiently serious to warrant a more extensive investigation or review to confirm the same result.

When *the Regulated Health Professions Act* (RHPA) was negotiated, the two levels of committee were retained by government (at CPSM's request) by modifying Part 8 through the provisions in Part 14. This section is unique to CPSM while all other regulated health professions coming under the Act have, or will have, one complaints/investigation committee. The Complaints Investigation Committee ("CIC") under the RHPA still divides matters into those appropriate for informal resolution and those that require more formal action.

Under the RHPA, CC and IC have different powers and considerations to address complaints as summarized below:

- CC
  - can conduct informal reviews
  - can utilize informal resolution through facilitated communication
  - has no powers to compel information or records
  - cannot make findings of fact, including whether standards were met, though can provide its opinions on these matters
  - can offer informal advice
  - does not include formal disposition and nothing is binding

- IC
  - conducts an investigation that can be expanded to include other issues found or suggested through the process
  - has far more extensive investigative powers including compelling information and records from anyone – members and non-members
  - can direct an audit or inspection of a member's practice
  - often involve interviews with the member, the complainant, or other witnesses
  - must provide a formal investigator's report to the member ahead of the IC meeting and allow the member to comment on the content of the report
  - can resolve a matter with formal discipline in the form of censure where the member agrees or seek formal discipline from a referral of formal charges to an Inquiry Panel for a formal hearing
  - can accept an undertaking for various conditions or education
  - can accept a surrender of license

- Like the CC, the IC cannot make formal evidentiary findings of fact, including credibility assessments where the facts are in dispute. That said, it, does comment on whether standards were met based on the information reviewed and has the power to make a decision and take action to address concerns it identifies. Where there are serious concerns and factual disputes regarding same, matters are referred to a Panel of the Inquiry Committee to make such findings following a hearing

Based on direction from the Federation of Medical Regulatory Authorities of Canada (FMRAC), decisions from both committees are now included on a COPC.

Statistics:

The total number of complaints heard by the CC are noted below, along with the number where the physician was felt to have had reasonable care or conduct such that no further action was required (NFA). The remainder of the complaints resulted in some sort of advice to the member or were referred to the IC for further review.

The IC receives direct referrals for matters that are of a more serious nature, or where a consultant opinion is likely to be needed. The total number of cases for each fiscal year is noted below and specifies the number of cases referred by the CC or at the request of the complainant. Council is asked to look carefully at the number of IC cases investigated at the request of the complainant. Recall that this represents a second review, regardless of what the CC determined about the care, including where it gave advice. Additionally, if the cases referred by the CC to the IC could be better predicted, the work would be contained in one, rather than two, reviews. In recent years we have begun to apply criteria for direct referral to IC and in 2021 only 10 cases were referred by CC to IC.

Of the 152 cases between 2016 and 2020 where the complainant asked for referral to IC, there were 22 cases where the IC offered advice or criticism where the CC felt no action was necessary. That is, the IC was somewhat more critical of the care or conduct than the CC, but there was no significant action or discipline that otherwise arose. Tracking the opposite direction (no further action where the CC offered advice or criticism) is difficult based on how decisions are categorized. Anecdotally one case is recalled where the IC was less critical than CC. The bottom line is that while the second review is more resource intense and represents duplicate work, it ultimately does not substantively change the outcome. Some complainants go on to appeal the IC decision, but the numbers below show that the IC decision is more often than not, accepted. This may represent an acceptance based on a more fulsome explanation by IC, or the complainant may simply give up.

Please note that the information below relates to the fiscal year ending April 30th of each year listed below and the total numbers represent **new** cases referred to each committee.

Year	CC total	NFA	IC total	CC to IC Referral	Complainant Request Referral to IC	Appeal of IC Decision
2016	177	97	80	27	31(39%)	11/31
2017	199*	73	69	30	25(36%)	12/25
2018	174	89	99	23	52(52%)*	34/52 *
2019	152	98	80	23	26(32%)	2/26
2020	114	83	73	20	18 (25%)	5/18
2021	124	74	79	10	22(28%)	5/22

*27 cases from one complainant worked their way through the process.

Current year to date - April 30 – November 7
New CC cases = 67 (project approximately 130 for fiscal year)
New IC cases = 67 (including 4 referrals from CC and 10 requests by complainants)

This indicates a projected approximately 130 new investigations to be opened this fiscal year, which is an unprecedented number of matters, all requiring the resources of the staff and IC members to conduct the necessary reviews and comply with the requirements of the RHPA.

While the above statistics represent the new cases received, there are always cases that remain unfinished at the end of April each year. Currently there are 57 open complaint files, and 100 open investigation files.

An Improved Process

Timeliness:

The Complaints and Investigation Department recognizes that the length of time to conclude investigations is often too long. Some investigations necessarily remain open for lengthy periods while opportunity is given for improvements through restrictions, supervision and/or remediation followed by repeat audits. It would be counterproductive to discourage or eliminate these important remedial efforts for the sake of apparent improved efficiency. The goal is to better communicate the reasons for delay in these circumstances. The number of open investigations continues to rise. We have been able to train a few ad hoc investigators with limited success. The work involves considerable skill and time and is most effectively done by physicians with dedicated time. Thus, we will be adding an additional medical consultant to our staff in the near future.

Triage:

Matters deemed to potentially pose a risk to public safety are necessarily prioritized. These include potential boundary violations or significant concerns about competency. When an allegation of a

boundary violation is received, the Assistant Registrar phones the physician to inform them of a serious allegation and advise them that a letter is being sent via password protected email within the hour. There is a brief discussion about the process, and an agreement for an applicable condition or restriction on practice to protect the public from the risk of harm is frequently sought. As an example, a verbal agreement may be given to have a chaperone present for specific encounters or examinations while a formal undertaking for same is presented for consideration. In extreme cases, members are required to cease practice. Interviews for these matters proceed expeditiously.

We have expanded the role of triage in determining whether a complaint will be considered by the CC or the IC, based on a risk assessment. This provides a consistent approach to concerns of a similar nature and may avoid unnecessary delay for matters where the CC may have reasonably been expected to ultimately refer the matter to IC.

Communication:

As noted above, significant efforts have been undertaken to improve communication, particularly with complainants. We strive to have personal communication with all complainants and generally offer to meet with complainants who have experienced significant grief.

Ease of Access:

We recently added a portal on the website that allows complainants to submit complaints and consent forms in this manner, rather than through mail or fax. It appears that this has filled a need, as we have received many complaints through the website and the volume of complaints has increased.

Transparency and Fairness:

Our process is detailed in information provided to complainants and members, through brochures and/or on our website. Formal policies that guide the Committees are available on the website. We acknowledge complainants are entitled to relevant information and members have a right to know the specifics of the concerns to which they must respond. This may involve further discussion with the complainant where necessary before asking for a member's response. Complainants have always been provided with the member's letter of response to their complaint, but we recognize that providing other information along the way may be helpful. This includes input from the medical consultant who has reviewed the matter as to concerns and how they might be addressed. This is particularly important where we are seeking a facilitated resolution.

Expanded processes for addressing complaints:

The RHPA has set out processes for addressing complaints, some of which have been underutilized by the Complaints and Investigations Department until recently for a variety of reasons. This section will explain how we plan to make greater use of the legislative tools of the RHPA.

Under the RHPA, the Registrar can do any of the following upon receipt of a complaint:

- refer to the Complaints Committee
- refer to the Investigation Committee
- encourage the complainant and the member to communicate to resolve the matter
- dismiss the complaint (new under the RHPA and not utilized until 2021)

The decision as to which of the above processes is most appropriate is based on a risk assessment, including analysis of the nature and extent of the concerns and what action is anticipated to best address the concerns identified.

Dismissal of a complaint by the Registrar is a legitimate action to take in rare and very specific circumstances. Complaints are dismissed when they are deemed to be trivial, vexatious, or unsustainable under our legislation (the RHPA). A matter is considered unsustainable where there is insufficient evidence to support that a relevant finding could be made, such as where the conduct is not relevant to the practice of medicine. The ability to dismiss complaints requires that clear and transparent reasons for such a dismissal are provided and communicated with a complainant as set out in the legislations. The process includes the ability of a complainant whose complaint has been dismissed by the Registrar to appeal the dismissal to a Panel of the CC which can either uphold the decision to dismiss or determine that an investigation should proceed.

Encouraging resolution by communication between the member and the complainant is an appropriate action for the Registrar to take in some circumstances where a more thorough review is not required to address any concerns raised in the complaint. The choice to encourage communication involves CPSM facilitating discussion or action through the Medical Consultant or other staff. This is appropriate for minor or straight forward matters such as failure to provide records, fill in forms, or where a minor or general deficiency in communication was perceived by the complainant. Generally, these matters that can be addressed through a simple request or as an opportunity for feedback and improvement without a lengthy process. This can involve the Medical Consultant communicating with a member and providing information and/or feedback to the complainant. These resolutions do not get considered by either a panel of the CC or the IC and there is no ability for a complainant to request further action. That said, we try to assure complainants whom we have assisted through this avenue that there has been adequate attention to their concerns, and adequate communication about same.

Referral to the CC versus the IC involves a risk assessment, based largely on the nature of the complaint and whether it is appropriate for an attempt at informal resolution at the CC level. It can be impacted by whether the member has current or previous matters of a similar nature. A triage tool has been developed to assist with consistency and transparency.

For matters referred to the CC, we are seeking to address more matters though facilitated communication. CPSM recognizes that many complaints result in breakdown of the physician-patient relationship, and we are hoping to improve conflict resolution such that this can be avoided. Members are provided with the letter of complaint and encouraged to approach their response with this in mind. Our letter to the member includes a gentle nudge to embrace informal resolution as being beneficial to all concerned. It includes the following specific language in that regard:

- *It is often helpful to offer both an explanation and an apology if you feel it is appropriate. CPSM acknowledges that words or actions can have unintended impact and the impact can often be alleviated through an explanation and apology.*
- *We are hopeful that if the concerns can be addressed, the professional relationship can be restored.*
- *If resolved through this process, the matter will not be included on any Certificate of Professional Conduct you request in the future.*

We are trialing and modifying this process over time. Currently complainants are provided with the member's response and a letter from the Medical Consultant detailing other relevant information such as an explanation of their medical record. This includes an invitation to speak with the Medical Consultant or the Public Support Advisor so that further questions or concerns can be addressed and resolved to their satisfaction. Otherwise, the matter will proceed to the Complaints Committee for a decision.

Where concerns about the care are raised by the Medical Consultant, or where resolution is not possible, the matter is also brought to the CC for a decision.

Matters are referred directly to the IC where the complaint deals with more serious allegations such as ethical breaches, involves a patient death, a missed or potentially mismanaged serious diagnosis, or resolution requires a peer opinion such that a consultant report is needed. No major changes are contemplated for this process. A second investigator is being added to staff and we anticipate we will need the IC to operate via two panels to increase efficiency.

Council Considerations:

We are seeking Council's approval of a new practice direction to formalize and inform the membership of the implementation of the above processes and the detailed expectations of them as

participants in the process. The draft document "Resolving Conflict and CPSM's Complaints and Investigation Processes" is provided as a separate document.

This Practice Direction also clarifies and fully sets out the expectations we have of our members in resolving conflict generally, regardless of whether a formal complaint with CPSM is filed. It goes on to set out the process in a very detailed manner. It has been written to mirror the language of the RHPA and make clear the source of the legislative source of the requirements it contains. It is intended for members and their lawyers such that all expectations are identified and explained. It is not intended to be the plain language explanation of the process that will be on the website for complainants or members to access as a starting point.

Changes in the process should be accompanied by education, and changes to the website will be necessary. It is equally important to assist members to begin to see the role of the complaints process, as an opportunity to assist with conflict resolution, and make improvements to their practice.

Ultimately, Council should consider whether CPSM should seek a legislative amendment to eliminate the portions of section 14 of the RHPA that directs two separate committees. There is a growing sense that having one process could allow us to apply the appropriate resources more consistently to the identified issue and avoid duplication of efforts. Unless and until that decision is made, this Practice Direction will provide the necessary direction to enable the Complaints and Investigation Committees and associated CPSM staff to move forward with efficient use of our resources. Further, much of it will still be applicable if one committee is ultimately responsible for all complaints.

Council Meeting:

A power point presentation will be provided at the Council Meeting to assist Councillors in understanding the proposed changes to the processes.

DECEMBER COUNCIL MEETING
DECEMBER 8, 2021
NOTICE OF MOTION FOR APPROVAL

TITLE: Complaints and Investigation Practice Direction

BACKGROUND

Council is asked to consider changes to the Complaints and Investigation process to better reflect the various options available under the RHPA. Attached is a revised Practice Direction which Council will be asked to approve. The changes in the Practice Direction reflect the changes in the process outlined in the Report to Council included in the previous attachment.

Approval of Practice Directions by Council do not require distribution for consultation to the members, stakeholders, and public.

PUBLIC INTEREST RATIONALE:

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

The public interest mandate has been addressed in the report in the previous item on the Council agenda.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 8, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

1. Council hereby approves the Practice Direction Resolving Conflict and CPSM's Complaints and Investigations Processes, as attached, to be effective immediately.

2. Council hereby rescinds the current Practice Direction Complaints, Investigations and Appeals effective immediately.

PRACTICE DIRECTION
Resolving Conflict and CPSM's Complaints and Investigation Processes

Initial Approval: **Effective Date:**

CONTENTS:

I. GENERAL REQUIREMENTS OF MEMBERS

1. Resolving Conflicts

1.1. CPSM considers addressing conflict as an essential aspect of communication and good medical practice. Members have a professional responsibility to facilitate effective communication despite difficulties, including with their colleagues, other health care providers and their patients and patients' family members. This includes addressing conflicts with any person in a professional and respectful manner.

1.2. The ethical obligations that are particularly relevant to addressing conflict with colleagues, other health care providers and the public in the Code of Ethics include:[1], [2]

> *31. Treat your colleagues with dignity and as persons worthy of respect. Colleagues include all learners, health care partners, and members of the health care team.*
>
> *32. Engage in respectful communications in all media.*
>
> *33. Take responsibility for promoting civility, and confronting incivility, within and beyond the profession. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.*
>
> *34. Assume responsibility for your personal actions and behaviours and espouse behaviours that contribute to a positive training and practice culture*

1.3. The ethical obligations that are particularly relevant to addressing conflicts in the context of members' relationships with their patients in the *Code of Ethics* include:[3, 4]

> *2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient*

[1] CPSM's Code of Ethics
[2] See also CPSM's Standard of Practice on the Duty to Report
[3] CPSM's Code of Ethics and Professionalism
[4] See CPSM's Practice Management Standard of Practice

has been given reasonable notice that you intend to terminate the relationship

….

5. Communicate information accurately and honestly with the patient in a manner that the patient understands and can apply, and confirm the patient's understanding.

1.4. At all times, members must be candid in their communications with patients, acknowledge where errors occurred and take appropriate actions to address any related potential harm.[5] It is important for members to recognize that their words and actions can have unintended impact. Members are expected to consider this when communicating with their patients.

1.5. When disagreement arises with a patient or a patient expresses discontent with the care provided by or the conduct of a member, the member should make a meaningful effort to resolve the issue with the patient before matters escalate.

1.6. In the context of a complaint:

1.6.1. Generally, members are expected to continue to provide care to a patient who submits a complaint, unless it is clear from the circumstances[6] that it would no longer be appropriate, or the patient declines to continue the relationship.

1.6.2. CPSM acknowledges that some complaints will result in a breakdown of the member-patient relationship. In all situations persons who complain to CPSM must be treated respectfully by members and not made subject, by any act or omission of a member, to any form of punishment, reprisal or retribution.

1.6.3. Members are prohibited from obstructing the making of a complaint by any person to the CPSM, including by threat or offering consideration.

2. Participation in CPSM Complaint and Investigation Processes

2.1. When conflicts or concerns are reported to CPSM, whether through a complaint from the patient or otherwise, members are expected to actively engage in good faith to resolve the matter both through informal resolution and/or more formal processes.

[5] See s. 9 of CPSM's Good Medical Care Standard of Practice

[6] Examples include complaints involving boundary violations or inappropriate conduct on the part of the member.

Duty to Cooperate and Statutory Obligations to Respond:

2.2. Members have professional, ethical, and statutory responsibilities relating to their participation in CPSM's complaints and investigations processes. The duty to cooperate owed by members includes the requirement that they:

2.2.1. act responsibly and make good faith efforts to cooperate with CPSM in relation to its supervisory and investigatory functions,

2.2.2. provide full, frank, and truthful information that is responsive to the issues raised,

2.2.3. not impede any review of their conduct, including a complaint or investigation, and

2.2.4. must be honest, open, and helpful to CPSM in fulfilling its regulatory functions.[7]

2.3. Withholding information, failing to meet deadlines without a reasonable explanation and providing false or misleading information are examples of a failure to cooperate in CPSM's regulatory functions. Such conduct can lead to findings of professional misconduct against a member.

2.4. Members are required to respond to the Assistant Registrar and Medical Consultants of CPSM in accordance with Part I of the Affairs of the College Bylaw. It provides at sections 103-105:[8]

> *103. When the Registrar, an Assistant Registrar or a Medical Consultant engaged by the College writes to a member with respect to any matter and requires a response,* ***the member 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 member 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 the College correspondence****.*
>
> *104. When reminder correspondence is sent to a member from the Registrar, an Assistant Registrar or a Medical Consultant engaged*

[7] See *Law Society of Ontario v. Daimon*, 2021 ONCA 255

[8] The Affairs of the College Bylaw

by the College and ***the member fails to respond in writing within 15 days from the date of the reminder correspondence, the member may be referred to the Investigation Committee****.*

105. A member who, without a reasonable excuse, fails to comply with section 103 or 104 may be found guilty of professional misconduct.

2.5. Members are also required to respond to Investigators pursuant to s. 99(1) of the RHPA.

II. THE ROLE OF THE REGISTRAR, ASSISTANT REGISTRAR, MEDICAL CONSULTANTS AND INVESTIGATORS

3. Registrar's Assessment of Action to be Taken Upon Receipt of a Complaint

3.1. The Registrar is responsible for determining what resources and statutory powers of CPSM's Complaints and Investigations Department and its statutory committees are best suited to resolve a particular complaint or address a concern about a member's care or conduct. The assessment is based on what is in the public interest and is made in accordance with CPSM's policies and procedures.

3.2. Pursuant to s. 91(2) of the RHPA, within 30 days of receiving a complaint, and after collecting and reviewing any additional information that may be required to determine which action should be taken, the complainant will be notified as to which of the following actions have been or will be taken by the Registrar in respect to their complaint:

3.2.1. encourage the complainant and the member to resolve the complaint through communication pursuant to s. 91(2)(a),

3.2.2. refer the matter to the Complaints Committee or to the Investigation Committee pursuant to s.91(2)(b), or

3.2.3. dismiss the complaint pursuant to s. 91(2)(c).

3.3. The Registrar may also treat information received about the conduct of a member or former member that may constitute conduct about which a finding could be made under s. 124(2) of the RHPA as a complaint and refer the matter to the Complaints Committee or the Investigation Committee pursuant to s. 91(2)(b). This practice direction applies to these matters which are for all relevant purposes treated as complaints, including where a patient or their legal/personal representative has not submitted a formal complaint to CPSM.

4. Assistant Registrar, Medical Consultants, and Investigators

4.1. The Assistant Registrar, Complaints & Investigations ("Assistant Registrar"), is primarily responsible for ensuring that complaints are processed, and investigations are conducted in accordance with the Part 8 of RHPA and CPSM's policies and procedures.

4.2. Medical Consultants implement many of the provisions of Part 8 of the RHPA and this practice direction in relation to processing complaints.

4.3. Investigators appointed in accordance with s. 96 of the RHPA implement many of the provisions of Part 8 of the RHPA and this practice direction in relation to the conduct of investigations.

5. Additional Procedures for Complaints about Regulated Associate Members

Medical Learners and Physician Assistant Students:

5.1. Where a complaint is received respecting the care or conduct of a medical learner or physician assistant student, that complaint must be sent to:

- 5.1.1. the medical learner or physician assistant student who is the subject of the complaint,
- 5.1.2. where applicable, the attending staff physician responsible for directing or supervising the medical care provided by the medical learner or physician assistant student, and
- 5.1.3. the appropriate Dean of either post graduate or undergraduate studies at the Max Rady College of Medicine, University of Manitoba.

Clinical Assistants and Physician Assistants:

5.2. Where a complaint is received respecting the care or conduct of a Clinical or Physician Assistant, that complaint must be sent to:

- 5.2.1. the Primary Supervisor, and
- 5.2.2. where applicable, the Responsible Supervising Physician.

6. Additional Procedures for Complaints Involving Virtual Medicine

6.1. Where CPSM receives a complaint respecting the care or conduct of a member practicing virtual medicine, CPSM will generally process the complaint irrespective of the jurisdiction where the patient is located.[9,10]

[9] See CPSM's Virtual Medicine Standard of Practice

[10] Note CPSO and CPSM's Memorandum of Understanding respecting Transport Medicine Services, and CPSM's Memorandum of Understanding with the Government of Nunavut

6.2. Where CPSM receives a complaint from a patient located in Manitoba who was provided care by virtual medicine by a person located in another jurisdiction and who is not registered as a member, CPSM will:

- seek to determine if the person who provided virtual care is registered in another jurisdiction as a health care professional, and
- consider whether the care provided was permitted under the RHPA and/or CPSM's Virtual Medicine Standard of Practice.

Based on these factors, CPSM will then determine whether:

- the complainant should be encouraged to report to another regulator,
- the complaint should be forwarded to another regulatory authority,
- prosecution for the unlicensed practice of medicine should be pursued, and/or
- whether some other legal action should be taken that accords with CPSM's public interest mandate.

III. RESOLUTION BY COMMUNICATION PURSUANT TO S. 91(2)(a)

7. Resolution by Communication

7.1. The Registrar will direct that a complaint be processed by encouraging resolution of a complaint by communication pursuant to s. 91(2)(a) where the nature and extent of the concerns raised are such that communication is considered as appropriate to resolve the concerns and referral to neither the Complaints Committee nor the Investigation Committee is in the public interest.

<u>The process for resolution by communication pursuant s. 91(2)(1) of the RHPA:</u>

7.2. Within 30 days of receiving a complaint, the complainant will be informed that the complaint has been received and that the Registrar has determined that the matter will be addressed by encouraging resolution by communication as facilitated by CPSM. If the complainant has not already provided a written consent to CPSM accessing their personal health information for the purposes of processing the complaint, they will be required to do so if CPSM requires the information to process the complaint.

7.3. Communication between the complainant and member will be facilitated by the Assistant Registrar or Medical Consultant assisting the parties in identifying and understanding the concerns and what is required of the member to address them with the goal of resolving the complaint. This will usually include:

7.3.1. exchanging written communications with the member about the complaint and identifying the concerns that the member is expected to

address in a written response which focuses on resolution of the concerns identified,

7.3.2. requiring the member to respond in writing and attempt to address the concerns by providing an explanation, taking appropriate steps in relation to the care or management of the patient and/or apologizing to the patient where an apology is appropriate, and

7.3.3. sharing the member's written response with the complainant and providing an assessment of the concerns and the response.

7.4. Where the Medical Consultant or Assistant Registrar is satisfied that the concerns have been addressed by the member in an appropriate manner through communication, the matter will be closed as being resolved by communication.

7.5. At any time that additional information or concerns about the care or conduct of the member arises during the process, including concerns about the member's approach to informal resolution, the matter may be referred by the Registrar to the Complaints Committee or the Investigation Committee.

IV. REFERRAL TO THE COMPLAINTS COMMITTEE PURSUANT TO S. 91(2)(b)

8. The Role of the Complaints Committee

8.1. The RHPA defines the role of the Complaints Committee as being to attempt to resolve a complaint informally if informal resolution is appropriate. It also gives it the authority to, upon resolving a complaint, provide advice about the practice of medicine to the member who is the subject of the complaint.

8.2. The Registrar will make a direct referral to the Complaints Committee where the nature and extent of the concerns raised are such that the potential for the Complaints Committee making a decision which includes providing advice to the member about the practice of medicine pursuant to s. 92.2(2) may be appropriate.

9. Processing a Complaint referred to the Complaints Committee

Initial Communication with the Complainant:

9.1. Within 30 days of receipt of a complaint that has been referred to the Complaints Committee, the complainant will be notified of the referral and advised of the next steps in the process, including that the complaint has, or will be, sent to the member for a formal written response, which will be shared with the complainant once received. If the complainant has not already provided a written consent to CPSM accessing their personal health information for the purposes of processing the complaint, they will be required to do so.

Member's Response:

9.2. The member will be sent a copy of the complaint and/or provided with a statement of the concerns referred to the Complaints Committee.

9.3. The member will be required to provide a written response which addresses the substance of the concerns and provides all pertinent particulars. That response will usually be required within 30 days unless the time is abridged or extended by the Assistant Registrar or Medical Consultant.

9.4. The member will also be advised that their response will be shared with the complainant for comment.

9.5. The member may be required to provide a copy of the relevant patient record, or a portion of it, where the member has access to it in accordance with *The Personal Health Information Act* ("PHIA"). Alternatively, CPSM may obtain patient records, including hospital records, from the appropriate trustee and will provide same to the member for the purpose of their response.

Further Input from the Complainant:

9.6. The member's response will be shared with the complainant and the complainant will be invited to comment on the member's response.

Gathering Additional Information and Informal Resolution:

9.7. At any time during the process, additional information relating to the complaint may be obtained by the Medical Consultant or the Assistant Registrar, such as patient records, billing information and prescribing records. This may also include inviting the complainant or the member to meet with the Assistant Registrar, Medical Consultant or their designate to provide further clarification to facilitate informal resolution of the complaint and/or the Complaints Committee Panel's review of the concerns raised in the complaint or the member's response.

Consideration by the Complaints Committee:

9.8. All complaints referred to the Complaints Committee must ultimately be considered by a Panel of the Complaints Committee selected pursuant to s. 92.1 of the RHPA once there is sufficient information to make a decision regarding the resolution of the complaint.

Decision of the Complaints Committee:

9.9. A Panel of the Complaints Committee may make one or more of the following decisions following its review:

9.9.1. determine that no further action is required to resolve the complaint if it is satisfied that the member's care or conduct was appropriate and/or reasonable,

9.9.2. provide advice to the member in accordance with section 92.2(2) of the RHPA where the Panel is of the view that such advice is appropriate to address any concerns it may have with the care or conduct of the member,

9.9.3. endorse an informal resolution of the complaint that has been achieved through the process, or

9.9.4. refer the matter to the Investigation Committee where it meets the criteria established by the Registrar set out below.

Informing the Complainant and Member of the Decision:

9.10. The decision and reasons of the Complaints Committee will be communicated to the complainant and the member in writing. If there is no complainant, the decision will be reported to the Registrar

9.11. The complainant will be informed of their right to request that the matter be referred to the Investigation Committee in accordance with section 92.2(3) of the RHPA if their complaint has not been resolved to their satisfaction, provided that the request is made within 30 days after being informed of the decision.

9.12. Where a complainant makes a request that the matter be referred to the Investigation Committee within the prescribed time, the complaint must be referred to the Investigation Committee.

V. REFERRAL TO THE INVESTIGATION COMMITTEE

10. The Role of the Investigation Committee

10.1. The role of the Investigation Committee is to investigate complaints and, where appropriate, attempt to resolve them informally.

10.2. The Registrar will refer a complaint to the Investigation Committee where the nature and extent of the concerns suggest that the statutory powers of the Investigation Committee and/or the Investigation Chair may be required. The decision to refer is discretionary and will depend on the circumstances of each case and guided by policy. Generally, complaints involving one or more of the following will

usually be referred to the Investigation Committee:

10.2.1. Concerns about care considered to be high risk to the public such as those which involve a serious diagnosis that was delayed or missed, an unexpected death of a patient, serious deficiencies in practice management and/or communication, including record keeping, communication of adverse results and/or other matters that could have a significant impact on patient care.

10.2.2. Concerns regarding conduct unbecoming or unethical or unprofessional conduct such as disruptive behaviour, boundary violations, sexual misconduct, serious lack of integrity, candour, and honesty, including failures to respond to or cooperate with CPSM and breaching undertakings or conditions on licensure.

10.2.3. Complex matters such as where care concerns involve treatment by a specialist or other care where it appears that the assistance of an external expert consultant will likely be required to assist the Committee with its assessment of the concerns.

10.2.4. A possible pattern of practice or repetitive inappropriate behaviour, care issues or conduct of a member.

10.2.5. Complaints received against a member while that member is the subject of an open investigation.

10.3. Section 92.2(3) of the RHPA provides that Investigation Committee must investigate all complaints that have been referred to it by the Complaints Committee at the request of a complainant whose complaint was not resolved their satisfaction by the Complaints Committee.

10.4. The Investigation Committee may try to resolve a complaint informally [s. 95, RHPA]. If it is not resolved informally, the Investigation Committee must appoint an investigator. [s. 96(1), RHPA]

11. The Role of Investigators

11.1. The Chair of the Investigation Committee is responsible for appointing a person as the investigator for each matter referred to the Investigation Committee.

11.2. In accordance with s. 98 of the RHPA, Investigators must investigate a complaint and may investigate any other matter related to the professional conduct or the skill and practice of the member that arises during the investigation. This will usually be done by the investigator formally expanding an investigation and providing written notice to the member that the investigation has been expanded and giving the member an opportunity to respond in writing, but there may be occasions where formal expansion is not considered necessary because the other matter is so closely related to the concerns identified in the complaint.

11.3. Investigators may engage legal counsel and employ any other experts they consider necessary to assist them with an investigation.

11.4. The powers of an investigator include doing one or more of the following at any reasonable time and where reasonably required for the purposes of their investigation:[11]

11.4.1. In all cases the investigator can require:

- the member to respond to the complaint in writing,
- any person, including the member, to answer any questions, or provide any information, that the investigator considers relevant to the investigation, and
- any person, including the member, to give the investigator any record, substance, or thing that the investigator considers relevant to the investigation and in the person's possession or under his or her control.

11.4.2. Either at the direction of the Investigation Committee or, if it is necessary to protect the public from exposure to serious risk, at the direction of the Chair of the Investigation Committee the investigator can:

- enter and inspect any premises or place where the member practices or has practiced medicine,
- inspect, observe, or audit the member's practice, and/or
- examine any equipment, materials or any other thing used by the member.

12. The Investigation Processes and Policies

Notice of the Investigation and the Member's Response:

12.1. The complainant will be informed in writing that an investigator has been appointed and that the investigated member has been advised of the complaint and is required to respond in writing.

12.2. The member:

12.2.1. will be advised in writing of the name of the investigator;

12.2.2. provided with reasonable particulars of the complaint to be investigated. This may be done by either providing the member with a copy of the complaint or by the investigator summarizing the concerns to be addressed;

12.2.3. advised that their response will be shared with the complainant where applicable;

[11] See section 99 of the RHPA.

12.2.4. required to respond in writing to the substance of the matter and provide all pertinent particulars by a date specified by the investigator; and

12.2.5. may be required to provide a copy of the relevant patient record, or a portion of it, where the member has access in accordance with *The Personal Health Information Act* (PHIA), or the Registrar or a Medical Consultant may obtain patient records, hospital records and such other information they deem necessary for the proper review of the complaint and will provide same to the member for the purpose of their response.

12.3. Where a matter is being investigated as a direct referral from the Registrar and the member is responding to the referral, the complainant will usually be provided with a copy of the investigated member's response and be invited to comment on the response, unless in the sole discretion of the investigator, there are serious concerns such as the privacy or safety of the member, which warrant a departure from the usual process.

12.4. Where the matter has been considered by the Complaints Committee and the member's response to the complaint has already been shared with the complainant, a copy of any further response to the referral to the Investigation Committee from the member will be provided to the complainant for their information. Where there is new information in the response on which the investigator determines the complainant should comment, the complainant will be invited to respond.

13. Investigating the Complaint

13.1. The investigator may take whatever additional steps and exercise their powers of investigation as they deem appropriate pursuant to sections 98 and 99 of the RHPA, including but not limited to doing one or more of the following:

13.1.1. inspecting, observing or auditing the investigated member's practice with the prior approval of the Investigation Committee,

13.1.2. meeting with the investigated member, the complainant and/or others with knowledge of relevant information and requiring them to answer questions or provide information,

13.1.3. obtaining records, substances or things from the investigated member, complainant, or others that the investigator considers relevant the investigation, and/or

13.1.4. engaging experts to assist with the investigation.

14. The Investigator's Report

14.1. The investigator will summarize their findings at the conclusion of an investigation in an Investigator's Report.

14.2. Before the matter is submitted to the Investigation Committee, a copy of the Investigator's Report will be provided to the member who will be informed of their right to make a written submission for consideration by the Investigation Committee before it makes a decision about the complaint.

14.3. Both the Investigator's Report and any written submission made by the member will be provided to the Investigation Committee before it makes a decision.

15. Decision of the Investigation Committee

15.1. The Investigation Committee will meet, but will not hold a hearing. After considering the Investigator's Report and any submission made by the member, it will make one or more of the following decisions in accordance with s. 102 of the RHPA:

15.1.1. refer the complaint, in whole or in part, to the inquiry committee;

15.1.2. direct that no further action be taken;

15.1.3. refer the complaint to mediation, if the committee decides that it is of concern only to the complainant and the investigated member, both of whom agree to mediation;

15.1.4. censure the investigated member, if

- at least one committee member has met with the investigated member and the investigated member agrees to accept the censure, and
- the committee has decided that no action is to be taken against the investigated member other than censure;

15.1.5. accept the voluntary surrender of the investigated member's registration or certificate of practice;

15.1.6. accept an undertaking from the investigated member that provides for one or more of the following:

- assessment of the investigated member's capacity or fitness to practise the regulated health profession,
- counselling or treatment of the investigated member,
- monitoring or supervision of the investigated member's practice,
- completion by the investigated member of a specified course of studies by way of remedial training,
- placing conditions on the investigated member's right to practice the regulated health profession, which may include the conditions relating to reinstatement set out in section 106; or

15.1.7. take any other action it considers appropriate that is not inconsistent with or contrary to this Act or the regulations or by-laws. This includes

criticizing the member or offering advice if the Committee is of the view that criticism or advice is warranted.

15.2. All decisions of the Investigation Committee are guided by established Policies of Council which are available on the website.

16. Informing the Complainant and Member of the Decision

16.1. The decision of the Investigation Committee and its reasons for any decision it makes will be recorded in a written Notice of Decision which will be provided to both the member and the complainant. Where there is no complainant, it will be provided to the Registrar.

16.2. If the Investigation Committee makes a decision under s. 102(1)(b), (f) or (g) of the RHPA, the complainant will be informed of their right of appeal under s. 108 of the RHPA to a Panel of the Executive Committee and what is required to initiate an appeal, including the requirement that the complainant must give the Registrar written notice of their appeal, including the reasons for it, within 30 days of receiving the Investigation Committee's Notice of Decision.

VI. DISMISSAL OF A COMPLAINT BY THE REGISTRAR

17. The Registrar's Decision

17.1. Where the Registrar is satisfied that a complaint is trivial, vexatious and/or that there is insufficient evidence or no evidence of conduct about which a finding could be made under s. 124(2) of the RHPA, the complaint will be dismissed pursuant to s. 92 of the RHPA. Any decision to dismiss under this section will be made in accordance with the following principles:

17.1.1. A complaint may be dismissed as trivial where the substance of the concerns raised are objectively lacking in substance and/or significance so as to not warrant a formal review and action by either the Complaints Committee or the Investigation Committee.

17.1.2. A complaint may be dismissed as being vexatious where the complaint appears to have been made for an improper purpose such as retaliation or to annoy, harass or damage the reputation of the member or to use the CPSM's complaints process as a means of achieving an inappropriate purpose. A complaint may also be vexatious if it brings up an issue or matter that has already been decided and the complainant is misusing the CPSM complaints process to relitigate it.

17.1.3. A complaint may be dismissed if it is plain and obvious that it cannot be sustained in that there is insufficient evidence or no evidence of conduct about which a finding could be made under s. 124(2) of the RHPA. This basis for dismissal requires the Registrar to be satisfied that there is no

reasonable prospect that the nature or extent of the concerns are such that the member could be subject to one of the following findings in relation to the care or conduct described in the complaint:[12]

- being guilty of professional misconduct or conduct unbecoming a member,
- having contravened the RHPA or a regulation, by-law, standard of practice, practice direction or code of ethics,
- having committed an offence relevant to their suitability to practice medicine,
- having displayed a lack of care, skill, or judgment in the practice of medicine,
- having demonstrated an incapacity or unfitness to practice medicine, and/or
- suffering from an ailment, emotional disturbance or addiction that impairs their ability to practice medicine.

18. Communication of the Decision

18.1. Within 30 days of receiving a complaint, the Registrar or a Medical Consultant will inform the complainant that the complaint has been dismissed pursuant to s. 92(1). The complainant will also be informed:

18.1.1. of the grounds and reasons for the dismissal,

18.1.2. their right to have the dismissal of their complaint reviewed by the Complaints Committee,

18.1.3. that their application for review must be in writing and state the reasons for the application, and

18.1.4. that their application must be received by CPSM within 30 days of the complainant being notified of the dismissal or it will not be considered.

18.2. The member will also be notified of the dismissal by providing the member with a copy of the complaint and the notice of dismissal.

19. Processing an Application for Review

19.1. Any application for review of the Registrar's decision to dismiss a complaint received within the prescribed time must be referred to a Panel of the Complaints Committee for a decision and will be processed as follows.

19.2. CPSM will acknowledge receipt of the application in writing and the complainant will be:

[12] See RHPA subsection 124(2)

19.2.1. advised of deficiencies, if any, in the application and asked to address them,

19.2.2. informed that they have a right to make a separate and additional written submission to supplement their application, which should be limited to 5 pages,

19.2.3. provided with a set date which will be the deadline for the filing of their written submission, and

19.2.4. informed that unless a further written submission is received from the complainant by the deadline, their application will be deemed to be their written submission, subject to any reasonable requests for an extension being made and granted in advance of the deadline.

19.3. Upon receipt of the complainant's written submission or after the filing deadline, whichever is sooner, a copy of the application and the complainant's submission will be provided to the member who will be advised:

19.3.1. that they have a right to make a written submission, which should be limited to five pages,

19.3.2. informed of a set date which will be the deadline for filing of their written submission,

19.3.3. informed that unless their written submission is received by the deadline, they will not be permitted to file a written submission, subject to any reasonable requests for an extension being made and granted in advance of the deadline.

19.4. Following receipt of the member's written submission or after the filing deadline has passed, whichever is sooner, the complaint, notice of decision of the Registrar, application for review and the written submissions filed by the complainant and the member within the prescribed time will be directed to a Panel of the Complaints Committee for a for a decision under s. 92(5) as to whether:

19.4.1. the dismissal will be confirmed if the Committee is satisfied that the complaint is trivial or vexatious or that there is insufficient evidence or no evidence of conduct about which a finding could be made under subsection 124(2); or

19.4.2. the dismissal will be reversed, and the Complaints Committee will either:

19.4.3. try to resolve the complaint informally under section 95 of the *RHPA*, or

19.4.4. appoint an investigator under subsection 96(1) of the *RHPA* and the complaint will be investigated by the Investigation Committee in accordance with its processes.

6.3.1 Both the complainant and the member will be notified of the decision made by the Complaints Committee and their reasons in writing.

DECEMBER COUNCIL MEETING
DECEMBER 8, 2021
NOTICE OF MOTION FOR APPROVAL

TITLE: Standard of Practice Exercise Cardiac Stress Testing

BACKGROUND

Cardiac Exercise Stress Testing is a diagnostic test used to assess the heart and its ability to handle exertion. The Standard prioritizes patient safety and addresses certain risk factors associated with this type of testing.

The Standard applies to practitioners supervising and interpreting the testing and medical directors of facilities where the testing occurs. This includes any facility performing exercise cardiac stress testing, whether it is hospitals, Health Authorities, private non-hospital medical or surgical facilities, and any clinics.

The Standard sets the requirements for minimum qualifications of members involved in the testing. It establishes the medical history, EKG, and assessment of the risk for that individual patient while setting out further requirements for patient safety, including documentation records. Finally, the medical director of the facility has requirements imposed to ensure one member is responsible for staffing, quality assurance, policies for safety, premises, and equipment. This is to ensure quality and patient safety.

The Working Group consisted of cardiologists from the private facilities in the community and also those working in hospitals and health authorities. The Medical Director of the WRHA Cardiac Sciences Program was also a member of the Working Group.

Feedback for Consultation

Council approved the draft Standard to be distributed for feedback from the members, stakeholders, and public. There were five comments, all of which are attached. Comments were only received from physicians.

The Working Group made the following changes to the Standard of Practice based upon comments. All changes are marked in red in the attached Standard.

1 – *Adult, not Pediatric* – The Standard is only applicable for adult cardiac stress testing. The Working Group considered that all pediatric stress testing occurs within the Variety Children's Heart Centre and its physicians, staff, processes, and procedures are sufficiently robust to not warrant additional regulatory requirements from CPSM.

2 – *Cardiopulmonary Exercise Testing* – Two respirologists inquired as to whether the Standard would apply to cardiopulmonary exercise testing and provided information on their qualifications and the specifics of that test. The Working Group noted that there is a different risk profile for the patients and this cardiopulmonary test occurs primarily in the hospitals or specific exercise facilities. It is also not included in the western provinces' standards of practice. Accordingly, cardiopulmonary exercise testing is not to be included in the standard. It was also clarified that myocardial perfusion imaging and stress echocardiogram are not included in the standard.

3 – *Advanced Cardiac Life Support* – The Working Group and Council both debated whether the requirement for members to have and maintain advanced cardiac life support (ACLS) should be included or not. After review, the Working Group recommended that it be deleted. It noted that the full set of equipment and drugs required for ACLS was not required in the facilities as the risk of requiring their use would be very infrequent, the cost of the equipment, drugs, and staff prohibitive for most facilities which would significantly limit care and access. Therefore, the up to date ACLS training would not be required, as the training requires the use of that specialized equipment and drugs. ACLS training also does not offer more robust knowledge than is required for the objective criteria of being eligible to review EKGs therefore, it was felt to be of little additional objective value. Knowledge of basic life support (BLS) and a plan to call for help (9-1-1 or Code 25/Code Blue in hospital) will be required as part of the operational manual for which the medical director will have responsibility.

Effective Date

The Working Group focused on the physical, educational, and procedural changes that some facilities must undertake to comply with the new Standard. They also want to ensure that the facilities could continue to provide this testing in the interim and certainly not close facilities which needed time to comply. The Working Group also noted that this Standard could change patient flow and wanted to address this proactively. The Working Group recommended an effective date of June 1, 2022.

Communications Strategy

While all CPSM members will be notified that this is a new Standard of Practice, the communications strategy will focus those members actively engaged in exercise stress testing. It is easy to identify the cardiologists and those working in the cardiology department. However, there are others who are not cardiologists, but are active in exercise testing (such as some specialists in internal medicine). The Registrar has a list of those non-cardiologists approved to interpret EKGs. Direct contact will be made to each of those advising them of the new Standard. Some of those will require Registrar approval of their training. CPSM will attempt to engage all actively to ensure compliance for patient safety.

CPSM will also research where this testing is being undertaken and will contact the facility's medical director to advise of the new Standard and ensure compliance by June 1, 2022.

PUBLIC INTEREST RATIONALE

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

Exercise Cardiac Stress Testing poses sufficient risk of potential harm to a patient to require specific standards of practice. These Standards of Practice provide assurances that those involved in this testing can best protect their patients through their qualification, processes, procedures, documentation, pre-testing, and staff requirements.

All Colleges in the Western provinces have a Practice Direction, Guideline, or Standard of Practice establishing minimum requirements of various aspects of the testing to enhance safety of this testing. This brings Manitoba up to a similar level as the other regulators.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 8, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Council hereby approves the Standard of Practice for Exercise Cardiac Stress Testing, as attached, to be effective on June 1, 2022.

Standard of Practice

Exercise Cardiac Stress Testing

Initial Approval: **Effective Date:** June 1, 2022

DRAFT

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

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

1. Preamble and Application

1.1 Exercise Cardiac Stress Testing poses sufficient risk of potential harm to a patient to require specific standards of practice.

1.2 This Standard applies to all members supervising and interpreting exercise cardiac stress testing for adults and the medical directors of facilities in which such exercise cardiac stress testing occurs, including in hospitals or other health authority facilities or non-hospital medical or surgical facilities or any other facility where performed.

1.3 This Standard does not apply to cardiopulmonary exercise testing, myocardial perfusion imaging, or stress echocardiograms.

2. Qualifications

2.1. Members supervising, interpreting, or serving as medical director for exercise cardiac stress testing must be:

2.1.1. Certificants of the Royal College of Physicians and Surgeons of Canada in Adult Cardiology or have specialist training in Adult Cardiology acceptable to the Registrar or

2.1.2. Approved by CPSM to interpret electrocardiograms ~~and maintain up-to-date certification in advanced cardiac life support~~ and provide satisfactory evidence of training and competence assessment in exercise cardiac stress testing[1]

[1] For guidance on training and competence, see Clinical Competence Statement on Stress Testing – A Clinical Competence Statement by the American College of Cardiology and the American Heart Association

3. Prior to Supervising Exercise Cardiac Stress Testing

3.1. Prior to supervising an exercise cardiac stress test the member must ensure the following are reviewed:
- 3.1.1. A clinical history and physical examination, including medications (if not done by the member supervising the test, then the information and findings must be verified).
- 3.1.2. Baseline electrocardiogram.
- 3.1.3. A real-time assessment of the risk of stress testing.

4. Quality and Patient Safety

4.1. The member responsible for supervising the test must remain onsite and available immediately while patients are undergoing exercise cardiac stress testing.

4.2. An exercise cardiac stress test may only be undertaken at a location that permits uninterrupted resuscitation to be performed on unstable patients during extrication on a stretcher and loading into an ambulance.

4.3. In the event of a death within the facility, the Medical Examiner must be notified prior to moving the body or removal of any lines or tubes from the body and CPSM notified within one week.

5. Responsibilities of the Medical Director

5.1. Medical Directors[2] of facilities where exercise cardiac stress testing occurs must be responsible to ensure:
- 5.1.1. staff are adequately qualified and have obtained sufficient training to participate in exercise cardiac stress testing including certification in Basic Life Support
- 5.1.2. continuous, adequate and effective direction and supervision of clinical staff.
- 5.1.3. an adequate quality assurance program is in place.[3]
- 5.1.4. The selection of testing procedures and equipment used.
- 5.1.5. equipment meets or exceeds the standards of the Canadian Standards Association or its equivalent and is maintained regularly
- 5.1.6. a manual outlining necessary office protocols and procedures (including those required to meet the standards for exercise cardiac stress testing) is maintained and current
- 5.1.7. a plan is in place for patient emergencies.

[2] In large institutional settings it is recognized the medical director may not have authority over all matters and may authorize others to act or the decisions may be made by the institution or the health authority.

[3] For ideas on quality assurance, see Clinical Competence Statement on Stress Testing – A Clinical Competence Statement by the American College of Cardiology and the American Heart Association, page 2 and other resources provided.

5.2. Medical Directors of facilities where exercise cardiac stress testing occurs must have at a minimum, the following medical emergency equipment and supplies readily available prior to exercise cardiac stress testing:

5.2.1. Stethoscope and blood pressure measurement device with various cuff sizes

5.2.2. Stretcher and backboard for cardio-pulmonary resuscitation if the stretcher is not suitable

5.2.3. ASA non-coated chewable tablets (81mg or 325 mg), and Nitroglycerin spray

5.2.4. automated external defibrillator

6. Documentation

6.1. The member supervising exercise cardiac stress testing must ensure a clinical record is created for each patient which contains, at a minimum, the following:

6.1.1. A relevant clinical history and physical examination

6.1.2. Current medication list

6.1.3. 12-lead electrocardiogram before, during and after the test

6.1.4. Name of the test performed

6.1.5. Total exercise time

6.1.6. Clinical response during and after testing

6.1.7. Presence or absence of arrhythmias

6.1.8. Measurement and character of ST-segments

6.1.9. Heart rates: estimated age-predicted target heart rate, and heart rate achieved

6.1.10. Blood pressure measurements before, during and after the test

6.1.11. Reason for stopping the test

Additional Resources

- College of Physicians and Surgeons of Alberta, Cardiac Exercise Stress Testing Standards
- Cardiac Care Network – Standards for the Provision of Electrocardiography (ECG) – Based Diagnostic Testing in Ontario 2017
- Recommendations for Clinical Exercise Laboratories – A Scientific Statement from the American Heart Association (Circulation 2009:119:3144-3161)
- Exercise Standards for Testing and Training – A Scientific Statement from the American Heart Association (Circulation 2013;128:873-934)
- Clinical Competence Statement on Stress Testing – A Clinical Competence Statement by the American College of Cardiology and the American Heart Association

DECEMBER COUNCIL MEETING
DECEMBER 8, 2021
NOTICE OF MOTION FOR APPROVAL

TITLE: Financial Management Policy

ISSUE:

The Financial Management Policy requires that reserves be appropriated for extraordinary number of Inquiry cases at a conservative cost estimate of $200,000 per case. A recent historical cost analysis suggested that $70,000 per case is a more realistic approximation.

BACKGROUND:

The relevant section of the Financial Management Policy reads:

1.8 In order to protect the fiscal soundness of future years and to build organizational capability sufficient to achieve ends in future years, the Registrar must maintain funds in the accumulated surplus of the College, as restricted accounts for the following specified purposes:

1.8.1 To cover the potential costs of determinable inquiry cases at $200,000 for each case in excess of one, which is the normal limit funded by regular operations

The above estimate was determined two years ago using a zero-based budgeting method that produced a low-cost scenario of $100,000, and a high-cost scenario of $200,000. The latter amount was adopted for the conservative Inquiry reserve appropriation.

A recent 7-year historical cost analysis on concluded Inquiry cases revealed that on average, a case incurred about $40,000 in total costs which include committee meeting expenses, legal and other professional fees (excluding staff time). The 3 most expensive of the 11 cases studied averaged $70,000. Accordingly, Management recommends updating the Inquiry reserve by adopting the $70,000 cost estimate as supported by the following motion:

Management discussed the adjustments to CPSM's Inquiry reserve involving a change in cost estimates.

The Committee unanimously approved that:

THE FINANCE, AUDIT AND RISK MANAGEMENT COMMITTEE HEREBY RECOMMENDS THE FOLLOWING AMENDMENT TO THE FINANCIAL MANAGEMENT POLICY:

1.8.1 TO COVER THE POTENTIAL COSTS OF EXTRAORDINARY NUMBER OF INQUIRY CASES BASED ON HISTORICAL COST THAT MANAGEMENT WILL ANALYZE ON A PERIODIC BASIS

Thus replacing:

1.8.1 To cover the potential costs of determinable inquiry cases at $200,000 for each case in excess of one, which is the normal limit funded by regular operations

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 8, 2021, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Section 1.8.1 of the CPSM Financial Management Policy be amended as follows:

1.8.1 To cover the potential costs of extraordinary number of inquiry cases based on historical cost that management will analyze on a periodic basis.

THE COLLEGE OF PHYSICIANS & SURGEONS

POLICY

Financial Management

Initial Approval: November 22, 2018 **Effective Date: January 1, 2019**

Reviewed with No Changes
June 19, 2020

Reviewed with Changes
June 21, 2019
December 8, 2021

FINANCIAL MATTERS

Auditor

1.1. At each annual meeting of the members, a member of, or a firm licensed by the Chartered Professional Accountants of Manitoba, must be appointed as auditor.

Office

1.2. The office of CPSM shall be at such place in Manitoba as the Council from time to time determines.

Fiscal year

1.3. The fiscal year of CPSM commences on May 1 and ends on April 30 of the following year.

Contracts

1.4. All deeds, contracts and agreements entered into on behalf of CPSM shall be in form and content approved and signed by one of the President, President Elect or Past President and by one of the Registrar or an Assistant Registrar, except that the following may be approved and signed by the Registrar alone or in the Registrar's absence, an Assistant Registrar:

1.4.1. Employment contracts (other than the Registrar's contract which shall be approved and signed by the President);

1.4.2. Contracts or agreements for the provision of services by an individual or a medical corporation;

1.4.3. Contracts, agreements, memoranda with no financial commitment; and

1.4.4. Agreements or contracts, other than in (a) or (b) above, where the total financial commitment over the term of the agreement or contract is less than $50,000.

Cheques

1.5. All cheques or other negotiable instruments to be sent out or requiring endorsement of CPSM require two signatures and

1.5.1. For transactions of $50,000 or less may be signed by any two of the President, President-Elect, Registrar, Assistant Registrar, or the Chief Operating Officer of CPSM; and

1.5.2. For transactions above $50,000 one of the signatures must be the President or President-Elect.

Banking

1.6. The Council or, subject to any directions given by the Council, the Registrar, may establish and maintain such accounts with a chartered bank, trust company or credit union as Council determines necessary from time to time.

Investments

1.7. The Audit and Risk Management Committee or, subject to any directions given by that committee, the Registrar, may invest funds of CPSM in accordance with Council's investment requirements set out in this Policy.

Restricted Accounts in the Accumulated Surplus:

1.8. In order to protect the fiscal soundness of future years and to build organizational capability sufficient to achieve ends in future years, the Registrar must maintain funds in the accumulated surplus of CPSM, as restricted accounts for the following specified purposes:

1.8.1. To cover the potential costs of extraordinary number of inquiry cases based on historical cost that management will analyze on a periodic basis. ~~To cover the potential costs of determinable inquiry cases at $200,000 for each case in excess of one, which is the normal limit funded by regular operations~~

1.8.2. To maintain an operating reserve to cover unanticipated operating deficit not covered by the above Inquiry reserve. The operating reserve should be the equivalent of one month's worth of core expenditures.

1.8.3. To maintain $500,000 reserve every five years to cover periodic IT upgrades, including, but not limited to, the member database software upgrade.

1.8.4. To cover the potential wind-up costs of CPSM of no less than $2,922,000 for the 2018-19 fiscal year, and thereafter adjusted annually for applicable inflationary and general salary increases.

1.9. To allow the Registrar flexibility to react quickly to operational needs, the Registrar may appropriate an amount of no more than $100,000 in a single year towards any discretionary program without requiring the approval of the President and President-Elect, or the Council.

1.10. The Registrar shall:
- 1.10.1. Evaluate the adequacy and appropriateness of the reserves at the end of each year, and incorporate in the budget of the following year a plan that supports or enhances the prescribed reserves, subject to the approval of the Audit and Risk Management Committee.
- 1.10.2. Determine the need for a special levy in case of any deficiency to the above reserves, provided the Registrar explores all other options first subject to the debt guidelines set forth in 6.2.1 below, and with the approval of the Council.

Restrictions on Registrar Discretion in Management of CPSM Funds

1.11. The Registrar must not expend more funds than have been received in the fiscal year to date unless both CPSM debt guidelines are met:
- 1.11.1. Not borrow more than $125,000 in order to obtain a financial advantage superior to cashing in investments.
- 1.11.2. Incur debt in an amount greater than can be repaid by certain, otherwise unencumbered revenues within 60 days.

1.12. The Registrar must:
- 1.12.1. settle CPSM payroll and debts in a timely manner.
- 1.12.2. settle CPSM payroll and debts in a timely manner.
- 1.12.3. aggressively pursue receivables after a reasonable grace period.
- 1.12.4. file all reports and make all payments required by government accurately and on time.

Requirements for Protection of CPSM Assets

1.13. For the protection of CPSM assets, the Registrar must:
- 1.13.1. Require staff with access to material amounts of CPSM funds to be bonded.
- 1.13.2. Receive, process, or disburse funds under controls which meet the Council-appointed auditor's standards.
- 1.13.3. Give due consideration to quality, after-purchase service, value for dollar, and opportunity for fair competition when making purchases.
- 1.13.4. Have the approval in writing of the President or President-Elect for any purchase not contemplated in the budget for an amount in excess of $50,000.

1.14. The Registrar must not acquire, encumber or dispose of land or buildings.

1.15. Registrar must not initiate legal action outside of the disciplinary process.

Investment Policies

1.16. CPSM investments must be managed in a way that preserves capital, provides necessary liquidity requirements, and adds value to the investments.

1.17. Speculation or leverage with CPSM investments is prohibited. This includes, but is not limited to, prohibition on equity investments, investments in options, futures and any type of derivative.

1.18. CPSM investments must be maintained in a conservative, low risk profile within the following parameters:

1.18.1. Short and medium term, cashable, fixed income obligations are permitted.

1.18.2. Permissible asset classes for CPSM investments are cash and money market securities and fixed income instruments, provided that each investment must have a minimum "A" or "R1" credit rating or equivalent as rated by a recognized rating service at the time of purchase.

1.18.3. Where liquidity is the primary concern, cash and money market securities are limited to treasury bills and other short-term government securities, bankers' acceptances, and guaranteed investment certificates with term to maturity of not more than 365 days.

1.18.4. Where long term growth is the primary concern, fixed income instruments are limited to federal and provincial bonds, municipal bonds, corporate bonds, and guaranteed investment certificates with a term to maturity of one to ten years.

1.18.5. Before making any investments, advice must be obtained from CPSM's professional portfolio advisor.

1.18.6. Performance of the investments must be reviewed at least semi-annually and reported to the Audit & Risk Management Committee and Council.

1.18.7. No investment may be made without taking into account the cash requirements for day-to-day operation of CPSM.

1.18.8. All parties involved in dealing with CPSM investments must disclose any conflict of interest.

COUNCIL AND COMMITTEE REMUNERATION AND EXPENSES

Council and Committee Expenses

2.1. The philosophy underlying honoraria and expenses recognizes the individual physician as a contributing member of the profession. Accordingly, honoraria and expense reimbursement are not intended as inducements. They are based on the wish of Council that there be no significant barriers to the participation of any member in the self-governing process.

Remuneration

2.2. Councillors, officers, and committee members are entitled to:

2.2.1. be reimbursed by the CPSM for reasonable expenses necessarily incurred in connection with the business of the CPSM in accordance with Council policies governing reimbursement established from time to time; and

2.2.2. receive honoraria for attending meetings (whether attendance is in person or by electronic communication) in connection with the business of the CPSM in accordance with Council policies governing honoraria established from time to time.

2.2.3. Notwithstanding clauses a. and b., members of a subcommittee of the Central Standards Committee, except for the Quality Improvement Committee and Area Standards Committees, are not entitled to be reimbursed by the CPSM or to receive honoraria by the CPSM. Members of all other subcommittees of the Central Standards Committee may be entitled to honoraria pursuant to the policies of their "sponsor" organization.

2.3. The members of Council, Council committees, designated subcommittees and the President's working groups are entitled to receive honoraria, travel time and reimbursement of expenses, all in accordance with the provisions of this section, at the rates determined annually by Council.

2.4. Honoraria and Stipends

2.4.1. Honoraria are intended to replace time away from fee generating practice. A member may choose not to submit a claim for honorarium and instead submit only a claim for expenses.

2.4.2. The following policies govern the payment of honoraria:

2.4.2.a. In submitting claims, "Morning" is the period preceding 12:30 p.m., "Afternoon" is from 12:00 noon - 6:00 p.m., and "Evening" is any period after 4:00 p.m.

2.4.2.b. A member who leaves at noon for a meeting scheduled for the afternoon is entitled to claim for the ½ day session, regardless of the actual time taken in the meeting.

2.4.2.c. A member who attends any meeting scheduled for 4:00 p.m. or later is entitled to claim for the evening rate regardless of the actual time taken in the meeting.

2.4.2.d. A member may claim an hourly rate up to the maximum of a half day or full day rate.

2.4.2.e. A member who attends meetings scheduled for 6 or more hours in one day is entitled to claim the full day rate.

2.4.2.f. The maximum that can be charged for a 24 hour period is the full day rate.

2.4.2.g. Full day Council meetings, regardless of the day of the week, will be compensated.

2.4.2.h. When a member participates in a meeting by telephone or in person, the member is considered to be in attendance and is entitled to full payment.

2.4.2.i. If a member is scheduled to attend a morning, afternoon or all day meeting, arrived late and/or left early, the member is not entitled to the full honoraria, but is entitled to be paid for the hours the member was present.

2.4.2.j. Canada Revenue Agency (CRA) regulations state that all honoraria payments are considered personal taxable income under the Income Tax Act of Canada and subject to withholding taxes and CPP deductions. A T4 slip will be issued for each calendar year. Council and Committee members may not bill honoraria through their corporations.

2.4.2.k. As the CRA permits individuals who are at least 65 years old but under 70 years old and who are receiving a Canada Pension Plan retirement pension to exercise an election to stop making CPP contributions by filing a CRA Form with CPSM and any other employer of that eligible individual. Members are advised to seek independent financial advice in this regard. Eligible members are responsible to file the completed CRA Form with the CPSM if they do not wish to contribute to the CPP plan.

2.4.2.l. Annual stipends are paid in recognition of the formal administrative roles held by the President, the President-Elect and the Investigation Chair. The stipend is intended to recognize the extra administrative time spent in discussions with the Registrar and staff (other than attendance at Committee meetings or other formal CPSM meetings covered by the payment of honoraria) in addition to covering the other administrative functions required by the holders of these positions to conduct the business of CPSM.

2.5. Travel Time

2.5.1. Subject to the exclusions for travel time set out in section 302, an hourly rate is billable for travel time for members, subject to the following policies, which govern the payment of travel time to meetings in Winnipeg.

2.5.1.a. Members who reside in the City of Winnipeg are not compensated for travel time to meetings held within the city.

2.5.1.b. Members who reside outside of the City of Winnipeg and who commute to meetings in Winnipeg may claim for travel time where the total commute exceeds one hour. This claim is in addition to the claim for honoraria in relation to attendance at the meeting.

2.5.1.c. Members who reside outside of Winnipeg and who travel more than one hour to attend meetings in Winnipeg, may charge for:

2.5.1.c.i. mileage for the round trip from the closest town or village to their residence to CPSM offices in Winnipeg provided they drive. The distance travelled will be calculated by CPSM staff using an internet satellite tracking system, selecting the “fastest time” calculation; and

2.5.1.c.ii. mileage for the round trip from the closest town or village to their residence to CPSM offices in Winnipeg provided they drive. The distance travelled will be calculated by

CPSM staff using an internet satellite tracking system, selecting the "fastest time" calculation; and

2.5.1.c.iii. travel time as calculated by CPSM staff using an internet satellite tracking system's fastest time calculation for the round trip rounded up to the nearest half hour unless the member flies to the meeting.

2.5.1.c.iv. if the member flies to the meeting, the calculation of time will be based on the flight time estimate provided by the airline used for travel. Time would be rounded up to the nearest half hour. No mileage will be paid for the portion of travel by air.

2.6. Expenses

2.6.1. CPSM will not reimburse any expense incurred unless the member provides the supporting receipt, with the sole exception of claims for parking at a meter. The following policies govern claims for reimbursement of expenses:

2.6.1.a. CPSM must have a receipt documenting the GST in order to claim the GST input tax credit. Accordingly, credit card slips are not accepted in lieu of receipts. Members must submit the actual receipt. **Expenses will not be reimbursed if the member does not submit the actual receipt.**

2.6.1.b. CPSM anticipates that members travelling on CPSM business may incur reasonable expenses for transportation, meals, telephone call to home or office, and accommodation. Any expense outside of these items would be regarded as unusual, and must be specifically authorized by the Registrar. Expenses will be reimbursed in accordance with the CPSM Expense Policy.

2.6.1.c. **Meals** - CPSM will reimburse expenses for meals on a per diem basis. Councillors and Committee members may claim the meal per diems only if the corresponding meal was not provided at the meeting/conference attended. Meals will be reimbursed at the following established per diem rates:

- Breakfast: $10
- Lunch: $20
- Dinner: $30

Receipts are not required – only adherence to the per diem rates. Alcoholic beverages are not eligible for reimbursement.

2.6.1.d. **Mileage** – This covers the actual costs of transport to and from the meeting for those travelling from outside Winnipeg. For those who use their cars, the calculation must be shown on the claim form. For other forms of transport, attach a receipt. Airfare is paid at the scheduled economy rate.

2.7. Annual Review

2.7.1. Annually, the Council must:

2.7.1.a. review the honoraria paid by CPSM,

2.7.1.b. review the stipend paid to the President, President-Elect and Investigation Chair,

2.7.1.c. fix the honoraria and stipends for the next fiscal year. In setting honoraria and stipends,

2.7.2. Council must take into account:

2.7.2.a. the amount of the honoraria or stipends paid by other organizations of a like nature;

2.7.2.b. the philosophy set forth above; and

2.7.2.c. the Audit & Risk Management Committee recommendation to Council as to the appropriate level for honoraria and the stipends.

2.8. Honoraria and Stipends

2.8.1. Honoraria

Hourly	$135
Half Day	$500
Full Day	$1000
Evening	$175

2.8.2. Stipends

President	$12,500
President-Elect	$5,000
Investigation Chair	$10,000

2.9. Remuneration for Area Standards Committee

2.9.1. Notwithstanding remunerations provisions for other Committee members, members of an Area Standards Committee shall be entitled to be:

2.9.1.a. paid $135.00 per hour of meeting time to a committee maximum of $10,800 per year (based upon 5 members x 16 hours x $135.00 = $10,800)

2.9.1.b. reimbursed for mileage from their office to the meeting place at .52 per kilometre provided that the member works outside of the municipality where the meeting is held.

CPSM
STRATEGIC ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Patient Records - Standard of Practice		Sep-20	Mar 21	Formed	Jun 21	21-Jul	21-Dec	21-Dec	**Delayed**	The Standards require further review on one matter and was not ready for the September Council meeting. Iready for December
Office Based Procedures - Standard of Practice		Jan-21		Formed	Jun 21	Jul 21	21-Dec	21-Dec	**Delayed**	Significant feedback in the consultation and a tight turn around time over the summer prevented finalization in Sept. It will be finalized for December.
Prescribing Practices Review		21-Sep		Almost Formed					**Not Started**	To commence in Fall of 2021. Still not started. This may be multi-year initiative
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners		Sep-21		Almost Formed					On Track	The Working Group is being finalized and first meeting established. This may be multi-year initiatives
Episodic Care, House Calls, Walk-Iin Clinics - Standard of Practice		Sep-21	Jun-21	Formed	22-Mar	22-Apr	22-Jun	22-Jul	On Track	First meeting in November
Streamlined Registration - Fast Track Application	FMRAC-Started								**Not Started**	
Streamlined Registration - Portable Licence	FMRAC-Started								**Not Started**	Amendments to Acts Required in many jurisdictions
Artificial Intelligence	FMRAC-Started								**Not Started**	

Last revised: December 2021

COUNCIL MEETING – DECEMBER 8, 2021

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

STAFF MATTERS

Dr. Nancy Dixon, the current Chief Medical Officer of the WRHA will join CPSM as the Medical Consultant in the Complaint and Investigations department. Dr. Dixon will start at CPSM in January 2022.

Mr. Paul Penner, the current Chief Clinical Officer at CancerCare Manitoba, will join CPSM as the Chief Operating Officer that will become vacant when Mr. Dave Rubel retires in January. Mr. Penner will also start in January 2022.

Join me in welcoming them to CPSM. I am delighted to attract such high calibre people to CPSM.

COVID-19 PANDEMIC

CPSM has had numerous inquiries into how members can address the health needs of patients who are unvaccinated. CPSM issued an FAQ to provide guidance. CPSM has also implemented a vaccination policy requiring staff and visitors to be vaccinated, or in the case of staff undergo frequent rapid testing for COVID-19. I can report that all staff are fully vaccinated.

Public Health Orders require health care workers, including physicians, to be vaccinated or to submit to very frequent testing prior to entering the Regional Health Authority or Government operated facilities. This Public Health Order does not apply to CPSM members in private clinics.

It is important for patient safety to ensure that a CPSM member does not transmit COVID-19, whether they practice in a private clinic or a regional health authority or government operated facility. CPSM required every non-educational member to disclose if they are unvaccinated for COVID-19. Upon receiving the notification from those few who are unvaccinated, CPSM has required those not subject to the Public Health Orders to enter into an undertaking with CPSM to test every 48 hours of seeing patients, log, their tests, report positive results to CPSM, and stop seeing patients if positive. A status update can be provided at the Council meeting.

MEETING WITH GOVERNMENT OFFICIALS

Public Health Orders Meetings
CPSM continues to attend biweekly meetings with the Chief Medical Officers of the Health Regions, Public Health leaders, Program Leads and Shared Health. The meetings are to discuss and collaborate on the next steps required during the COVID-19 pandemic.

Chief Medical Officers Meetings
I attend monthly meetings with the Chief Medical Officers of the regional health authorities. Matters discussed are wide ranging and include health care resources and constraints, workforce planning, COVID, ongoing and new health care transformation initiatives from the government.

Deputy Minister Meeting
After an extensive period of no meeting due to COVID, I met with the Deputy Minister, along with the CPSM president, the Assistant Registrars, and the General Counsel. I can provide a verbal account to Council.

Manitoba Clinical Leadership Council
I continue to attend their monthly meetings.

MEDIA

CPSM was mentioned in the media in the following instances during this quarter 12 times.

CPSM secured print, TV, and radio coverage to inform CPSM members and the public about the new Standard of Practice for Virtual Medicine. Dr. Ainslie Mihalchuk appeared on CBC Radio, CBC News Winnipeg, and the Winnipeg Free Press wrote an article focusing on the standard. The standard gained national attention, and quotes from it aired on CBC National News and Global News National. The Virtual Medicine Standard was re-tweeted by several physicians in other provinces seeking similar rules.

CPSM also received inquiries from the media regarding CPSM's expectations on members treating unvaccinated patients and providing medical exemption notes. Statements with a link to the Vaccine FAQs on the website were provided.

Additionally, media sought CPSM's comments on complaints against certain physicians for various matters. CPSM did not comment as restricted by the RHPA confidentiality provisions.

RENOVATIONS

The CPSM office renovations on the 2nd floor of the building have been completed and occupancy permits secured. The Complaints & Investigations department relocated to that space in November.

QUALITY DEPARTMENT

Physician Health Program

- very busy with new referrals as well as some flare ups with current monitored physicians
- 59 new referrals from January 1 – November 19, 2021
    - In 2020, the referrals by the same date was 52
    - In 2019, the referrals by the same date was 43
- In 2021, Mental Health - Anxiety/Depression is the leading illness disclosed
    - This category sits at 15% of total referrals
    - Stress/Burnout is the next highest category at 14% of total referrals, followed by Cancer at 8%

MANQAP

- Most of the diagnostic facilities that received temporary accreditation due to the COVID-19 pandemic have had an accreditation inspection or are scheduled to have their inspection before the end of the calendar year
- Work continues implementing and updating processes for Non-Hospital Medical Surgical Facilities including adapting and implementing new operational standards to ensure that accreditation inspections are congruent with the revised Accredited Facilities Bylaw

Quality Improvement

- Program operations continue – back up to full pace
- Completing a study on inter-rater reliability to calibrate performance of chart reviews
- Auditor Training Workshop planned for late January 2022. Attendees will be accepted based on CPSM needs/gaps – across all audit programs
- Continued expansion into different specialty areas year by year
- Quality Improvement Committee work has been subsumed by Central Standards Committee – work going smoothly

Audits and Monitoring

- The total qualifying audits for 2021 in the Quality Department Audits program is 67.
- This includes:
    - 11 referred audits.
    - 40 age triggered audits (ages 74-75) which also includes repeat age triggered audits.
    - 16 cancelled audits because the physician no longer engages in clinical work, is planning to retire by end of the year or has already retired.
- Age triggered audits will be moving onto age 73 and 72 year old physicians for 2022.

Prescribing Practices Program

- Substance Use and Addictions Program Grant (ends in June 2022)
    - 3 Opioid Agonist Therapy workshops held (Sep, Oct, & Dec 2021)
    - Suboxone Recommended Practice Manual work continues - new chapters posted as created (3 chapters since September).
    - responded to 47 Opioid Agonist Therapy Mentoring requests from external professionals seeking advice/support.

- 3 Registrar referrals processed (1 closed with educational recommendations completed, 1 reviewed and eventually referred to Standards, 1 reviewed and eventually referred to Investigation)
- 2 Cases reviewed after receiving external concerns (1 case reviewed and referred to Investigation, 1 case reviewed and referred to Standards).
- 20 Cases reviewed & prescribing advice provided to external callers seeking support.
- Chief Medical Examiner Death Review Program: backlog of cases reviewed from Sept to Dec 2020.
- 4 Methadone & Suboxone prescribing approvals reviewed & issued (24 new approvals total thus far in 2021).
- Expert meeting conducted to revise Practice Direction for Pain & Palliative Methadone Prescribing approvals & training.
- contributed 5 articles in total to September & December Newsletters.

CHANGES IN COUNCIL MEMBERHSIP UNDER THE RHPA

There will be various changes to Council membership as required under the RHPA. The main changes are to have defined limits to Councillor terms and a transition to a shrinking Council. The following is an explanation of these changes. The RHPA provides: 14(2) A person may be a council member for more than one term. But a person must not be a member for more than twelve consecutive years. At the end of their respective terms, Dr. Lindsay (2006-2022) and Drs. Manishen, Postl, and Ripstein (all elected/appointed in 2010) will reach 12 consecutive years in 2022 and will no longer be eligible for Council. Due to his position as past President, Dr. Ripstein will continue for one further year 2022/23.

Under the RHPA the size of Council decreases from 23 to 18, while public representatives increase from 4 to 6. Therefore, the balance of public representatives to physicians change.

In 2022 there will be 5 positions in Winnipeg, which is down from the current 8. In 2020 Brandon and Westman combined into one seat – West. In 2022 Eastman and Central combine into one seat – East. Also, in 2022 Interlake, Parkland, and North combine into one seat – North. There are also two positions for President and Past President. The two University seats combined into one seat In 2022 there will be an election for:

- Three Winnipeg Council positions currently held by four (plus a vacant seat): Drs. Manishen, Sigurdson, Smith, and Kumbharathi
- One position in the East region currently held by Drs. Shenouda and Convery
- One position in the North region currently held by Drs. Stacey (North), Lindsay (Interlake), and Elliott (Parkland)
- A new associate position (currently held by Mr. Chris Barnes P.A. and requires an annual election)

We have been actively pressing Government for the renewal of appointments of Councillors and Committee members. Nothing has yet been received by Government.

See attached chart for all Councillors' terms.

TRUTH AND RECONCILLIATION – ADDRESSING ANTI-INDIGENOUS RACISM

Advisory Circle

CPSM is working with the Chair of the Advisory Circle to finalize the membership. There have been several discussions and initial meetings to begin to launch this initiative.

Manitoba Indigenous Cultural Safety Training

CPSM Senior Staff and Dr. Elliott, Dr. Shenouda, and Ms Agger are participating in the Manitoba Indigenus Cultual Safety Training program. This training is designed for service providers who provide health care directly or indirectly with Indigenous people in Manitoba. Modified from the original British Columbia training to include Manitoba content, many employees at regional health authorities are required to take this training. It is on-line asynchronous learning with a component of group discussion.

This training addresses a need in the province to offer more accessible and flexible cultural education options for service providers. It aims to improve the ability to develop and deliver culturally safe care. The facilitated and self-paced training program will increase knowledge of Indigenous people in Canada, enhance self-awareness, and strengthen the skills needed to work more respectfully and effectively with Indigenous people.

The Advisory Circle may consider whether this training program should be mandatory for CPSM members.

The Path: Your Journey Through Indigenous Canada

In January 2021 all CPSM staff completed the online Indigenous cultural awareness course called *The Path: Your Journey Through Indigenous Canada.* This course is offered through NVision Insight Group. https://nvisiongroup.ca/the-path-indigenous-cultural-awareness

This high quality on-line asynchronous course is designed to help learn about First Nations, Inuit and Metis peoples and communities in Canada. The course has five modules that are broadly titled:

1. What's in a Name?
2. Defining Moments for Indigenous Peoples in Canada.

3. A Colonial History
4. It's the Law; and
5. Relationship Building with Indigenous Peoples.

I, along with Staff, learned a great deal from completing this online course and recommend that all Councillors complete the course as well. If this is something Council is interested in doing I will arrange the course for Councillors. I consider it important that all Councillors have this common knowledge as a basis to make decisions on how CPSM will address Truth and Reconciliation.

The Advisory Circle may consider whether this training program should be mandatory for CPSM members.

FINANCIAL SUSTAINABILITY PLAN

To ensure that CPSM core services receives sufficient financial support to maintain long term financial stability, a financial sustainability plan is under consideration. This was discussed at the November 23, 2021 Finance, Audit, & Risk Management committee meeting and I would like to discuss this further with Council.

INTERNATIONAL MEDICAL GRADUATES WORKING GROUP

A Working Group of the Dean & Vice-Provost, Rady Faculty of Health Sciences was struck to review the present structure and processes of the Medical Licensure Program – International Medical Graduates Program. The mandate of the Working Group is to review the present structure and processes of the MLP-IMG Program.

- To allow reorientation to a "training program" from an assessment program within Family Medicine and Post Graduate Medical Education structures.
- To review admission criteria and selection processes to focus on candidates already living in Manitoba.
- To ensure that outcomes of training of the MLP-IMG align with those of family medicine graduates
- To explore opportunities to integrate educational experiences with those of the Family Medicine residency program, including those of distributed education sites
- To review remediation processes and supports
- To build in appeal processes within the Post Graduate Medical Education framework.
- To examine means of managing issues of professional roles from and EDI framework.
- To ensure learner wellness and support their development of the Family Physician professional identity
- To review processes that allow for stakeholder engagement in an ongoing way.

To date there have been 2 meetings with 2 more scheduled in the next couple of months.

Councillor Term Listing

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Council Members	Yrs	# of Terms	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Start Date	End Date	Comments
Public Representatives																														
Agger, Ms Leslie	1	1																										8-Jul-19	19-Jun-23	CPSM Appointed
Albrecht, Ms Dorothy	2	1																										23-Jul-18	19-Jun-24	CPSM Appointed
Magnus, Ms Lynette	2	1																										16-Jun-18	15-Jun-22	CPSM Appointed
McPherson, Ms Marvelle	3	1																										13-Apr-17	28-Feb-21	Government Appointed-remain until new apt
Fineblit, Mr. Allan	3	1																										30-Mar-17	28-Feb-21	Government Appointed-remain until new apt
Penny, Ms Leanne	2	1																										17-Dec-19	16-Dec-21	Government Appointed-unless reappointed
Councillors																														
McLean, Dr. Norman		1																										19-Jun-20	19-Jun-24	
Seager, Dr. Mary Jane		1																										19-Jun-20	19-Jun-24	
Suss, Dr. Roger	2	2																										19-Jun-20	19-Jun-24	
Penner, Dr. Charles		1																										19-Jun-20	19-Jun-24	
Shenouda, Dr. Nader(PE)	4	2																										6-Jan-16	19-Jun-22	\
Convery, Dr. Kevin	2	1																										15-Jun-18	15-Jun-22	/ June 2022 - 2 positions transition to 1
Vacant Position																												15-Jun-18	15-Jun-22	\Position vacant September 20, 2021
Manishen, Dr. Wayne	10	3																	X									15-Jun-10	15-Jun-22	\
Sigurdson, Dr. Eric	5	2																										15-Jun-14	15-Jun-22	\ June 2022 - 5 positions transition to 2
Kumbharathi, Dr. Ravi	2	1																										15-Jun-18	15-Jun-22	/
Smith, Dr. Heather	1	1																										15-Jun-18	15-Jun-22	/
Elliott, Dr. Jacobi (P)	1	1																										15-Jun-18	15-Jun-22	\
Lindsay, Dr. Daniel	14	4																	X									15-Jun-06	15-Jun-22	\ June 2022 - 3 positions transition to 1
Stacey, Dr. Brett	1	1																										1-Nov-19	22-Jun-22	/
Associate Member																														
Barnes, Mr. Christopher	1	1																										9-Jun-21	22-Jun-22	Yearly Elected
University Appointed (Yearly)																														
Postl, Dr. Brian	10	11																	X									15-Jun-10	22-Jun-22	\ June 2020 - 2 positions transition to 1
Ripstein, Dr. Ira (PP)	10	11																		X								15-Jun-10	22-Jun-23	/ Past President completes term
as of September 20, 2021																														

Red lines indicate election years

X means member has completed 12 years of service and is not eligible to run for Council that year

Light blue indicates person came in on a by-election

Gold represents term as President Elect, Green represents term as President, and Yellow represents term as Past President

COUNCIL MEETING – DECEMBER 8, 2021

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met in person on November 16, 2021, for the first time since February 5, 2020. The December Council Agenda was reviewed, and various other matters were discussed.

The Executive Committee held an electronic vote to Appoint Dr. Shenouda to the IC Committee for the October 22, 2021, meeting as the other members were conflicted.

Members of the Executive Committee formed an IC Appeal Panel that met on October 4, 2021, to hear five IC appeals.

Members of the Executive Committee formed a Panel for a Cancelation of Registration Hearing which took place on November 16, 2021.

Respectfully Submitted,
Dr. Jacobi Elliott
President, CPSM and Chair of the Executive Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. **Independent Auditor's 2022 Audit Plan**
   - The independent auditing firm Deloitte presented their annual Audit Plan for the upcoming audit of CPSM's Financial Statements for the fiscal year 2021-22.
   - An Audit Report and the CPSM Annual Financial Statements will be presented to Council at the June 2022 AGM.

2. **October 31, 2021 - 2nd Quarter Financial Statements**
   - Management presented the October 31, 2021 financial statements of CPSM.
   - At the end of the 2nd quarter CPSM posted an excess of revenue over expenditures of $142,000, which is an increase from the original budget deficit of $200,000.
   - This positive variance has resulted from lower than anticipated expenses for this period due to the timing of when these expenditures will actually be realized.

3. **Investment portfolio update**
   - The Committee received an overview and update of the CPSM investment portfolio.
   - Letters of Compliance with the approved investment policies of CPSM will be received by CIBC Private Wealth Management for the May 2022 Committee meeting.
   - Management presented a recommended investment strategy for the remainder of the fiscal year 2021-22 as CPSM GIC's are maturing in the near future.

4. **CPSM Financial Sustainability Plan**
    - In order to sustain the CPSM mandate to protect the public and its core services, management has developed a financial sustainability plan to ensure that ongoing budget support and resources will be available to meet these goals going forward.
    - This preliminary plan was discussed with the committee.

Respectfully submitted
Dr. Nader Shenouda
Chair, Finance, Audit & Risk Management Committee

PROGRAM REVIEW COMMITTEE REPORT:

Program Review Committee (PRC) – Meeting Date: 24 November 2021

PRC has adopted a new format for the meeting agendas. A consent agenda was introduced at the November Committee meeting. In an effort to make Committee meetings more efficient and effective, routine and non-contentious business has been consolidated for a single (en bloc) motion.

Diagnostic Facilities
Most of the facilities that received temporary accreditation due to the COVID-19 pandemic have had an accreditation inspection or are scheduled to have their inspection before the end of the calendar year. The facilities that remain on temporary accreditation are due to high COVID-19 volumes in the area or due to travel challenges (weather). Work continues around COVID-19 testing requirements and the demand for rapid testing.

Non-Hospital Medical Surgical Facilities (NHMSF)
Work continues implementing and updating processes for NHMSF. The focus has been upon implementing new operational standards to ensure that accreditation inspections are congruent with the revised Accredited Facilities Bylaw which came into effect in June 2021.

Respectfully submitted
Dr. Wayne Manishen
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

Complaints Received between
01-May-2021 and 18-Nov-2021

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Complaint Received	Total Cases
May/2021	11
June/2021	5
July/2021	6
August/2021	21
September/2021	18
October/2021	11
November/2021	4
Grand Total	76

Length of time required to acknowledge complaints received
between 01-May-2021 and 18-Nov-2021

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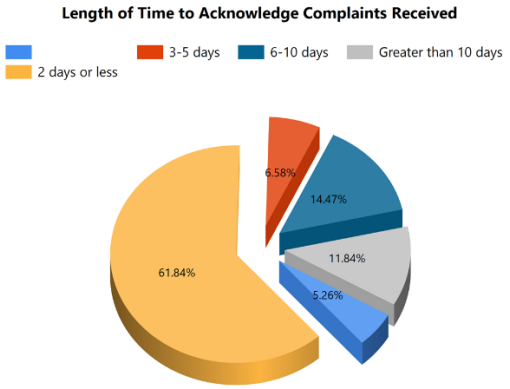
Complaints Acknowledge In	Total Cases
	4
2 days or less	47
3-5 days	5
6-10 days	11
Greater than 10 days	9
Total number of complaints cases in time period:	76



Length of time required to resolve complaints for cases closed between
01-May-2021 and 18-Nov-2021

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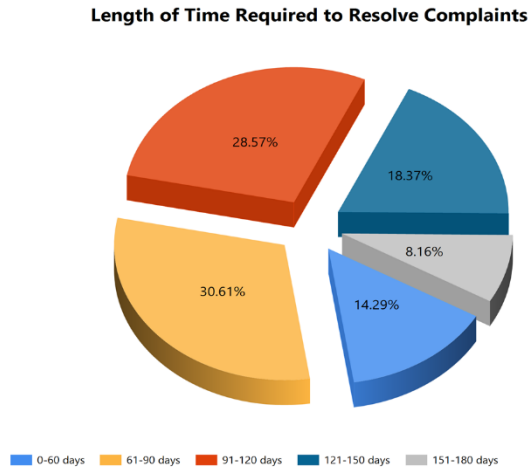
Complaints Cases with	Total
0-60 days	7
61-90 days	15
91-120 days	14
121-150 days	9
151-180 days	4
	49



Respectfully submitted
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

The Investigation Committee has been extremely busy since the last Council meeting. We've met monthly and here are the summaries of those meetings.

September 2021
- 16 cases
- No further action = 6
- Criticism/Advice = 7
- Refer to Inquiry = 2
- Censure = 1

October 2021
- 12 cases
- No further action = 5
- Criticism/Advice = 3
- Undertaking for Education = 1
- Refer to Inquiry = 2
- Deferred = 1

November 2021
- 8 cases
- No further action = 2
- Criticism/Advice = 4
- Undertaking for Education = 1
- Censure = 1

I would personally like to thank Karen Bullock Pries for the amazing job she has done basically doing the work of two people this past while. She continues to provide excellent Investigator Reports that help to facilitate the important work being done by this committee.

Please let me know if you have any questions.

Respectfully submitted
Dr. Kevin Convery
Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

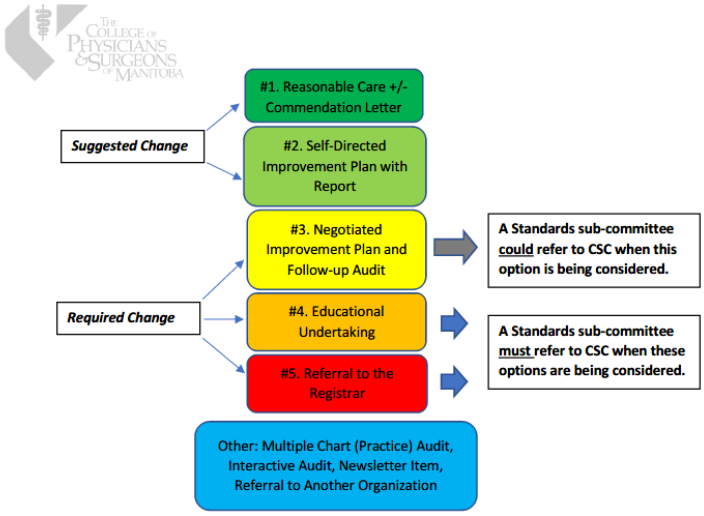
Central Standards Committee (CSC) Activities

The CSC met October 22, 2021.

AGE TRIGGERED/REFERRED AUDITS 2021

Two audit reports were reviewed at the October 22, 2021, CSC meeting. The following were the outcomes determined from that meeting.

1	#1 outcomes
	#2 Outcomes
1	#3 outcomes
	#4 outcomes
	#5 outcomes



Standards Sub-Committees Draft Operational

A Standards Sub-Committee Guide to Operations has been developed to summarize the advice of the CSC approved working group and was shared with all sub-committees to set the expectation that all sub-committees will start using our required formats and consistent approaches.

Two sessions were made available to the Chairs of all current sub-committees operating in Manitoba. They were held on November 18, and November 22, 2021, the turnout and participation from the various Chairs was very positive.

Standard of Practice – Documentation in Patient Record

The CSC reviewed the Standard of Practice – Documentation in Patient Record and had made some comments/suggestions to sections 2.1 and 2.2 of the draft standards. A letter was forwarded to Dr. Brett Stacey, Chair of the working group their consideration.

Respectfully submitted
Dr. Roger Suss
Chair, Central Standards Committee

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EVALUATION OF COUNCIL

The CPSM is interested in your feedback regarding your experience at the Council meeting. The results of this evaluation will be used to improve the experience of members and to inform the planning of future meetings.

	Strongly Disagree	Neutral	Strongly Agree	Comments
How well has Council done its job?				
1. The meeting agenda topics were appropriate and aligned with the mandate of the College and Council.	1	2	3	
2. I was satisfied with what Council accomplished during today's meeting.	1	2	3	
3. Council has fulfilled its mandate to serve and protect the public interest	1	2	3	
4. The background materials provided me with adequate information to prepare for the meeting and contribute to the discussions.	1	2	3	
How well has Council conducted itself?				
5. When I speak, I feel listened to and my comments are valued.	1	2	3	
6. Members treated each other with respect and courtesy.	1	2	3	
7. Members came to the meeting prepared to contribute to the discussions.	1	2	3	
8. We were proactive.	1	2	3	

Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate decision-making and the decision was clear.	1	2	3	
Feedback to CEO/Staff				
12. Council has provided appropriate and adequate feedback and information to the CEO	1	2	3	
My performance as an individual Councillor				
13. I read the minutes, reports and other materials in advance so that I am able to actively participate in discussion and decision-	1	2	3	
14. When I have a different opinion than the majority, I raise it.	1	2	3	
15. I support Council's decisions once they are made even if I do not agree with them.	1	2	3	
Other				
16. Things that I think Council should start doing during meetings:				
17. Things that I think Council should stop doing during meetings:				