December Council Meeting

Wednesday, December 14, 2022 | 8:00 a.m. |

AGENDA -Revised

CPSM Office – Brown Room
1000 – 1661 Portage Avenue

Time		Item		Action		Page #
5 min	8:00 am	1.	Opening Remarks			
0 min	8:05 am	2.	Agenda – Approval			
0 min	8:05 am	3.	Call for Conflict of Interest			
5 min	8:05 am	4.	Consent Agenda i. Council Meeting Minutes – September 29, 2022 October 26, 2022 ii. Practice Direction Appeals from Investigation Committee Decisions iii. Central Standards Bylaw iv. Standard of Practice – Withholding and Withdrawing Life Sustaining Treatment	For Approval	Dr. Elliott	4
75 min	8:10 am	5.	Prescribing Rules 1. Tramadol and Tramacet 2. M3P Continuation 3. Practice Direction - Verbal Orders for M3P 4. Section 56 Exemption 5. Standard of Practice – Prescribing Requirements 6. Practice Direction – Electronic Transmission of Prescriptions	For Information	Dr. Shenouda/ Dr. Ziomek	44
15 min	9:25 am		Standard of Practice Social Media	For Approval for Consultation	Ms Kalinowsky	126
30 min	9:40 am	6.	Performance Metrics	For Information	Mr. Penner	64
20 min	10:10 am	7.	"Break"			
15 min	10:30 am	8.	Practice Direction Prescribing Methadone or Buprenorphine/naloxone	For Approval	Dr. Mihalchuk	76

15 min	**10:45 am**	**9.**	**CPSM Risk Management Policy**	**For Approval**	**Mr. Penner**	**87**
15 min	**11:00 am**	**10.**	**Strategic Organizational Priorities**	**For Information**	**Dr. Elliott**	**94**
15 min	**11:15 am**	**11.**	**President-Elect Election**	**Election**	**Dr. Elliott**	**97**
20 min	**11:30 am**	**12.**	**Committee Report (written, questions taken)** **Executive Committee** **Finance, Audit & Risk Management Committee** **Complaints Committee** **Investigations Committee** **Program Review Committee** **Central Standards Committee**	**For Information**	**Dr. Elliott**	**100**
20 min	**11:50 am**	**13.**	**Registrar's Report**		**Dr. Ziomek**	**105**
20 min	**12:10 pm**	**14.**	**Review of Self-Evaluation of Governance Process – In Camera**			
4 hrs 30 min	**12:30pm**		**Estimated time of sessions**			

Regulated Health Professions Act

Duty to serve the public interest

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

CPSM Mandate

10(2) A college has the following mandate:

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

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

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

COUNCIL MEETING –DECEMBER 14, 2022
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Consent Agenda**

BACKGROUND:

In order to make Council meetings more efficient and effective the consent agenda is being used. Routine and non-contentious business has been consolidated into a 'consent agenda'. Many organizations and their committees use consent agendas. Below is how the consent agenda works:

1. The President decides which items will be placed on the consent agenda. The consent agenda appears as part of the normal meeting agenda.
2. The President authorizes the consent agenda and associated documents distribution in time for members to read and review.
3. At the beginning of the meeting, the President asks members if any of the consent agenda items should be moved to the regular discussion items.
4. If a member requests an item be moved, it must be moved. Any reason is sufficient to move an item. A member can move an item to discuss the item, to query the item, or to vote against it.
5. Once the item has been moved, the President may decide to take up the matter immediately or move it to a discussion item.
6. When there are no items to be moved or if all requested items have been moved, the President notes the remaining consent items.

The President-Elect can move to adopt the consent agenda, and a seconder is required. A vote will be called on approving the items in the consent agenda. There will be a single (en bloc) motion for all the items included in the consent agenda.

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

i. Council Meeting Minutes – September 29 and October 26, 2022
ii. Practice Direction – Appeals from Investigation Committee Decisions
iii. Central Standards Bylaw
iv. Standard of Practice – Withholding and Withdrawing Life Sustaining Treatment

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

All items on the consent agenda are approved as presented.

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

MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on September 29, 2022 in person.

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 Dorothy Albrecht, Public Councillor
- Mr. Chris Barnes, Associate Member
- Dr. Kevin Convery, East
- Dr. Jacobi Elliott, President
- Ms Lynette Magnus, Public Councillor
- Dr. Norman McLean, Winnipeg
- Ms Marvelle McPherson, Public Councillor
- Dr. Lisa Monkman, North (excluding items 7 & 8)
- Ms Leanne Penny, Public Councillor
- Dr. Ira Ripstein, Past President
- Dr. Nader Shenouda, President Elect
- Dr. Roger Süss, Winnipeg - Virtually

STAFF:
- Dr. Anna Ziomek, Registrar
- Dr. Ainslie Mihalchuk, Assistant Registrar
- Ms Kathy Kalinowsky, General Counsel
- Mr. Paul Penner, Chief Operating Officer
- Ms Karen Sorenson, Executive Assistant
- Ms Jo-Ell Stevenson attended for Item 10 & 11

REGRETS:
- Ms Leslie Agger, Public Councillor
- Dr. Caroline Corbett, Winnipeg
- Mr. Allan Fineblit, Public Councillor
- Dr. Peter Nickerson, University of Manitoba
- Dr. Charles Penner, West

GUESTS: none

2. ADOPTION OF AGENDA

IT WAS MOVED BY MR. CHRISTOPHER BARNES, SECONDED BY MS LEANNE PENNY:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. 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. CONSENT AGENDA

IT WAS MOVED BY DR. IRA RIPSTEIN, SECONDED BY MS MARVELLE MCPHERSON:
CARRIED

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

- Council Meeting Minutes – June 22, 2022
- Practice Ready Assessment – Fields of Practice Additions
- Standard of Practice – Seatbelt /Helmet Exemptions
- Standard of Practice - Female Genital Cutting/Mutilation

5. TRUTH AND RECONCILIATION COMMISSION: ADDRESSING INDIGENOUS RACISM IN MEDICAL PRACTICE – ADVISORY CIRCLE RECOMMENDATIONS

The TRC Advisory Circle recommended to Council that seven initiatives be initiated and further developed to address Indigenous-specific racism in medical practice. As head of the TRC Advisory Circle, Dr. Monkman explained the importance of each recommendation.

IT WAS MOVED BY DR. IRA RIPSTEIN, SECONDED BY MR. CHRISTOPHER BARNES:
CARRIED

That Council adopt the following recommendations of the Truth and Reconciliation Advisory Circle and direct further development on each recommendation:

1. CPSM to issue an **Apology and Statement** by CPSM on Indigenous Racism
2. CPSM **Land Acknowledgment**
3. **Standard of Practice** – Practicing Medicine to Prevent Indigenous Racism
4. **Restorative Justice** Approach to Complaints and Investigations (includes – Creating a Culture for Receiving and Addressing Complaints by Indigenous Patients)
5. Mandatory **Indigenous Cultural Safety and Anti-Racism Training** for CPSM Registrants and Staff
6. **Mentorship/Leadership** at CPSM (Includes Creating an Open Culture to Support Indigenous Physicians)
7. **Definition of Indigenous Racism** and gather examples of Racism by Medical Professionals

6. TRUTH AND RECONCILIATION COMMISSION: APOLOGY AND STATEMENT

CPSM has prepared an Apology and Statement to Indigenous Peoples of Manitoba for the racism experienced in their medical care in Manitoba. It recognizes current and past racism, apologizes for the failures of CPSM, and pledges improvement.

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

That Council approves the Apology and Statement to First Nations, Inuit, and Métis People as distributed.

7. STANDARD OF PRACTICE EPISODIC VISITS, HOUSE CALLS, AND WALK-IN PRIMARY CARE

As a Strategic Organizational Priority, this Standard provides the expectations of the profession to manage episodic visits, house calls, and walk-in primary care to provide optimal continuity of care for patient safety.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS MARVELLE MCPHERSON:
CARRIED:

That Council approves the Standard of Practice – Episodic Visits, House Calls, and Walk-in Primary Care as attached to be effective November 1, 2022.

8. STANDARD OF PRACTICE VIRTUAL MEDICINE

This Standard was updated to reflect more experience by practitioners and patients with virtual medicine and its diverse widespread use.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS LYNETTE MAGNUS:
CARRIED

That Council approves the revisions to the Standard of Practice Virtual Medicine, as attached.

9. REGISTRATION DEPARTMENT OVERVIEW

Ms Jo-Ell Stevenson gave a presentation of the various classes of registration and the registration process and requirements in Manitoba.

10. FAST TRACK REGISTRATION

Council was advised of a new registration process to permit fully licensed physicians from another Canadian jurisdiction to register with CPSM via a fast-track registration process.

11. STRATEGIC ORGANIZATIONAL PRIORITIES

Council was provided with an update of the Strategic Organizational Priorities for 2022/23, including the ongoing review of Standards of Practice, Practice Directions, and Policies.

12. COMMITTEE REPORTS

The following Reports were presented to Council for information:

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

13. REGISTRAR/CEO'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at CPSM. In addition to her written report, Dr. Ziomek gave an update on the meeting with the Deputy Minister as well, answered questions presented by the Councillors.

14. IN CAMERA SESSION

An in-camera session was held with, and then without Dr. Ziomek, and the President advised there was nothing to be recorded in the minutes.

There being no further business, the meeting ended at 12:45 p.m.

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Dr. J. Elliott, President

_____

Dr. A. Ziomek, Registrar

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

MINUTES OF COUNCIL

A special meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on October 26, 2022 via ZOOM videoconference.

1. CALL TO ORDER

The meeting was called to order at 05:35 p.m. by the Chair of the meeting, Dr. Jacobi Elliott.

COUNCILLORS:
- Ms Leslie Agger, Public Councillor
- Dr. Kevin Convery, Morden
- Dr. Caroline Corbett, Winnipeg
- Dr. Jacobi Elliott, Grandview
- Mr. Allan Fineblit, Public Councillor
- Ms Lynette Magnus, Public Councillor
- Ms Marvelle McPherson, Public Councillor
- Dr. Lisa Monkman, Scanterbury
- Dr. Peter Nickerson, Winnipeg
- Dr. Charles Penner, Brandon
- Ms Leanne Penny, Public Councillor
- Dr. Ira Ripstein, Winnipeg
- Dr. Heather Smith, Winnipeg
- Dr. Roger Süss, Winnipeg

REGRETS:
- Ms Dorothy Albrecht, Public Councillor
- Mr. Chris Barnes, Associate Member Councillor
- Dr. Norman McLean, Winnipeg
- Dr. Nader Shenouda, President-Elect

MEMBERS:
- Nil

STAFF:
Dr. Anna Ziomek, Registrar
Ms Kathy Kalinowsky, General Counsel
Mr. Jeremy de Jong, Legal Counsel
Ms Karen Sorenson, Executive Assistant

2. ADOPTION OF AGENDA

IT WAS MOVED BY MR. ALLEN FINEBLIT, SECONDED BY DR. ROGER SUSS:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. 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. ELIMINATING CERTAIN LMCC REQUIREMENTS FOR PROVISIONAL REGISTRATION

It is recommended that Council request that Government immediately amend the *CPSM General Regulation* to eliminate the requirements of the MCCQE1 for the provisional (specialty practice-limited) and provisional (family practice-limited) classes. These provisional registrants will still be required to undergo a practice ready assessment and monitoring.

IT WAS MOVED BY DR. IRA RIPSTEIN, SECONDED BY DR. CHARLES PENNER:
CARRIED

That Council request that Government immediately amend the *CPSM General Regulation* to repeal subclause 1(h) and clause (3) from sections 3.16 and 3.19 of the *CPSM General Regulation*

5. APPOINTMENT TO EXECUTIVE COMMITTEE

Due to conflicts of interest of a number of the members of the Executive Committee, in order to form an Appeal Panel to hear the current two appeals, two members of Council need to be appointed to the Executive Committee for the sole purpose of hearing the two appeals.

IT WAS MOVED BY DR. HEATHER SMITH, SECONDED BY DR. PETER NICKERSON that:
CARRIED

Council appoint Drs. Roger Suss and Carrie Corbett to the Executive Committee for the sole purpose of sitting on an Appeal Panel to hear the two appeals. Case numbers AP5865 and AP6086

There being no further business, the meeting ended at 6:19 p.m.

_____
Dr. J. Elliott, President

_____
Dr. A. Ziomek, Registrar

COUNCIL MEETING – DECEMBER 14, 2022

CONSENT AGENDA ITEM

TITLE: **Practice Direction Appeals from Investigation Committee Decisions**

BACKGROUND

There are three requirements for the appellant to file in an appeal as per the requirements in sections 108(2) and 109(3) of the RHPA:

1. Notice of appeal (s. 108)
2. Reasons (s. 108)
3. Written Submission (s. 109)

CPSM has considered that these three items can be included together within the 30-day deadline. The statutory 30-day deadline is only for the notice and reasons in section 108. But CPSM included the written submission within the 30-day requirement.

Government has provided legal advice that the notice/reasons and the written submission are to be two separate documents under these provisions of the RHPA.

The *Appeals From Investigation Committee Decisions – Practice Direction* can be amended to include the following provision:

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

This will have the effect of extending the appeal period by a further 30 days beyond the 30 days already permitted for the written notice and reasons for appeal.

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

CPSM always strives to ensure it correctly interprets the law. Having a difference of opinion with Government on this provision, CPSM will defer to Government and will permit the complainant to have a separate opportunity to submit a written submission.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the Practice Direction – Appeals from Investigation Committee Decisions as per attached.

PRACTICE DIRECTION
Appeals from Investigation Committee Decisions

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

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

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

1. Appeals from Investigation Committee Decisions

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

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

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

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

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

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

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

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

~~1.4.~~1.5. The complainant may make a written submission within 30 calendar days after providing written notice of appeal and reasons. No written submission can be accepted after the appeal period has expired

2. Procedure on Receipt of Notice of an Appeal

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

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

3. Date of Hearing the Appeal

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

4. Appeal Material

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

5. Meeting

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

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

6. Appeal Panel Decision

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

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

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

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

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

COUNCIL MEETING - DECEMBER 14, 2022

CONSENT AGENDA ITEM

SUBJECT: Removing List of Standards Committees from the Central Standards Bylaw

BACKGROUND:

As per the RHPA, CPSM must establish a standards committee that is responsible for supervising the practice of medicine by members and may establish any subcommittees of the standards committee. The committee or a subcommittee may review the professional competence of a member.

The Central Standards Bylaw establishes two Standards Committees in the bylaw:

- CPSM Maternal and Perinatal Health Standards Subcommittee;
- CPSM Child Health Standards Subcommittee.

These are no longer CPSM Standards Subcommittees and it is recommended that they be deleted from the Bylaw.

The WRHA Standards Committee (aka Winnipeg Regional Health Authority, Patient Safety and Quality Research Committee) is recognized by the Manitoba Evidence Act – Medical Research Committee Regulation.

The Central Standards Bylaw also mentions other WRHA Standards Committees – WRHA Oral Health and WRHA Clinical Psychology. This is problematic. The Standards Committees are created under Part 14 of the RHPA which only applies to CPSM and for reviewing the professional competence of a member, ie a medical professional – not a nurse, dentist, psychologist, or any other regulated health professional. These two committees are not Subcommittees under the Central Standards Committee. Under the Health System Governance and Accountability Act Government may create other Standards Committees for other regulated health professions. It is recommended that reference to the Oral Health and Clinical Psychology Standards Committees be deleted from the Central Standards Bylaw since these are not affiliated with CPSM.

The Central Standards Bylaw lists other Standards Committees in the Schedule to the Bylaw under the following headings:

- area standards subcommittees
- hospital standards subcommittees
- non-hospital facilities where members provide health care
- provincial standards subcommittees.

Under each Schedule there is a list of Standards Subcommittees. Some are active, some not. Some have had their names changed due to regional amalgamations, but the names of the committees have not been updated. Changes to the Bylaw, including Schedules to the Bylaw, can only be amended by Council, and by the entire CPSM membership at the Annual General Meeting. This level of governance is too hands on for the overall CPSM membership and is also overly restrictive in establishing Standards Subcommittees. It is the Central Standards Committee that has the requisite knowledge as to whether there should be a subcommittee, not the overall CPSM membership.

It is recommended that the Central Standards Bylaw be amended to only include the category of Standards Subcommittees and the at the Schedules be deleted. It is recommended that the Central Standards Committee create a policy whereby it approves the Standards Subcommittees. It is recommended that Central Standards Committee be charged with establishing a list of Approved Standards Subcommittees.

We will also use this opportunity to update the reference to the new legislation – *The Health System Governance and Accountability Act* - and delete the reference to the now repealed *Hospitals Act*.

These changes to the bylaw will have to be ratified by the general membership in June 2023 but none the less, become effective immediately.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

A. Council approve Bylaw amendments to:
    1. delete reference to the
        - CPSM Maternal and Perinatal Health Standards Subcommittee
        - CPSM Child Health Standards Subcommittee.
        - WRHA Oral Health Standards Committee
        - WRHA Clinical Psychology Standards Committee
    2. Delete references to the Schedules of Standards Subcommittees
    3. Delete the four schedules to the Central Standards Bylaw containing lists of all Standards Subcommittees.
    4. Permit the Central Standards Committee to approve all Standards Subcommittees.
    5. Update the reference to the new legislation – *The Health System Governance and Accountability Act* - and delete the reference to the now repealed *Hospitals Act*.

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

Central Standards Bylaw

The College of Physicians and Surgeons of Manitoba

(Enacted by the Councillors of the College of Physicians and Surgeons of Manitoba

on November 22, 2018 repealing and replacing Bylaw #3 and 3D under The Medical Act)

Effective Date January 1, 2019

TABLE OF CONTENTS

Definitions

1. In this Bylaw:

"Central Standards" means the Central Standards Committee of CPSM established pursuant to subsection 182(1) of *The Regulated Health Professions Act*.

"Committee Member" means each member of Central Standards or of a Subcommittee, whether or not the person is a registrant of the CPSM.

"Legal Proceeding" means any civil proceeding, inquiry, or arbitration, in which evidence is or may be given, and includes:

a. an action or proceeding for the imposition of punishment by fine, penalty, or imprisonment, to enforce any Act of the Legislature,
b. an action or proceeding for the imposition of punishment by fine, penalty or imprisonment to enforce any regulation made under an Act of the Legislature, and
c. a proceeding before a tribunal, board or commission.

"Mandatory Reporting Obligation" means a requirement imposed by the legislation of a regulated health profession whereby members of a regulated health profession are required to disclose specified information respecting colleagues to the regulatory authority of that regulated health profession.

"Record" means a record of information in any form and includes any information that is written, photographed, recorded or stored in any manner, on any storage medium or by any means, including by graphic, electronic or mechanical means.

"Subcommittee" means a subcommittee of Central Standards.

"WRHA Standards Committee" means the Standards Committee established by the Winnipeg Regional Health Authority pursuant section 23.1 of the *Health System Governance and Accountability Act* ~~to s.24 of *The Hospitals Act*~~, and each subcommittee of that committee.

"Witness" in addition to its ordinary meaning, includes a person who, in the course of a legal proceeding:

a. is examined for discovery;
b. is cross examined on an affidavit made by him or her;
c. answers interrogatories;
d. makes an affidavit as to documents, or
e. is called upon to answer any question or produce any document, whether under oath or not.

Establishment of Subcommittees of Central Standards Committee

~~2. The Subcommittees of Central Standards are:~~
- ~~a. CPSM's Maternal and Perinatal Health Standards Subcommittee;~~
- ~~b. CPSM's Child Health Standards Subcommittee;~~
- ~~c. each area standards subcommittee identified on Schedule "A";~~
- ~~d. each hospital standards subcommittee identified on Schedule "B";~~
- ~~e. each non-hospital facility where members provide health care and identified on Schedule "C":~~
- ~~f. each provincial standards subcommittee identified on Schedule "D".~~

1. All Standards Subcommittees must be approved by the Central Standards Committee to be appropriately constituted.

Committee Membership

2. CPSM must appoint a physician as the Chair of each ~~WRHA~~ Standards Committee. ~~, except~~:
   - ~~a. the Oral Health Program Standards Committee;~~
   - ~~b. the Clinical Health Psychology Program Standards Committee;~~
   - ~~c. any other WRHA Standards Committee that Central Standards determines does not require physician membership.~~

3. A Committee Member must not participate in a review of the work of any individual over whom the Committee Member has direct administrative or disciplinary responsibility.

Evidence as to Proceedings of Subcommittee

4. Subcommittees must establish a clear process for:
   a. educating Committee Members on the legal privilege that applies to witnesses in a legal proceeding respecting Standards Committees,
   b. distinguishing those documents to which the legal privilege applies, from those documents to which the privilege does not apply, and
   c. managing documents to which the privilege applies in a manner consistent with the protection provided in *The Evidence Act.*

5. ~~Section 5 of this Bylaw shall apply with necessary changes in points of detail to physicians who sit as members of a WRHA Standards Committee.~~

Review by Central Standards Committee or its Subcommittees

6. Central Standards and each Subcommittee:

a. must review any matter referred to it by the Registrar, and
b. may, of its own motion, make such inquiries or reviews that it considers appropriate to promote high practice standards amongst members.

7. A review by Central Standards may include any one or more of the powers permitted in sections 99 and 100 of the RHPA. A Subcommittee may exercise the powers in the RHPA subsections 99(1) (d) (e) (f) on its own initiative but must request authority from the Chair of the Central Standards Committee in order to exercise any other powers in sections 99 or 100 of the RHPA.

8. Where a review involves a member in an educational class, the correspondence about the review must be simultaneously sent:
   a. where the member is a medical student or physician assistant student, to the attending staff physician responsible for the medical care provided by that student and to the Associate Dean responsible;
   b. where the learner is a resident or resident limited, to the attending staff physician responsible for the medical care provided by that resident and to the Associate Dean responsible.

Referral to Administration

9. If, on a preliminary review of a matter, Central Standards determines that the administration of a hospital, regional health authority, or other facility where Members provide health care services is responsible for the matter, Central Standards Committee may refer all or part of the matter to the Registrar to refer the matter to the appropriate administration, and for that purpose, may disclose the facts pertaining to the matter to that administration.

Action by Central Standards

10. Central Standards may take such steps as it determines may improve the knowledge, skill or safety of one or more members in carrying on the practice of medicine, including but not limited to do one or more of the following:
    a. make recommendations to a member, a Committee, or to the administration of a hospital, regional health authority, or other facility where members provide health care services;
    b. refer a member to the Registrar in accordance with section 14 of this Bylaw;
    c. advise the Executive Committee to direct a member to complete a specified course of studies or supervised practical experience pursuant to section 182(4) of the RHPA;
    d. accept a member's undertaking in accordance with section 15 of this Bylaw;
    e. develop guidelines or protocols for consideration by Council.

11. Where Central Standards has a concern about the practice of a member of a health care discipline other than a physician or where a Mandatory Reporting Obligation exists, Central Standards may refer that concern to one or both of the administration of a hospital, regional health authority, or other facility where Members provide health care services, and the Registrar for referral to the regulatory body responsible for the practice of that health care discipline in Manitoba in accordance with Section 18 of this Bylaw.

Action by Subcommittee

12. A Subcommittee may take such steps as it determines may improve the knowledge, skill or safety of one or more members in carrying on the practice of medicine, including but not limited to do one or more of the following:
    a. make recommendations to a member;
    b. advise Central Standards to:
        i. make recommendations to the administration of a hospital, regional health authority, or other facility where members provide health care services;
        ii. refer a member to the Registrar in accordance with section 14 of this Bylaw; or
        iii. request and accept a member's undertaking in accordance with section 15 of this Bylaw and, where such advice is given provide complete supporting information and documentation to Central Standards;
    c. develop guidelines or protocols for consideration by Central Standards.

Referral to the Registrar

13. Central Standards may refer a member to the Registrar in the following circumstances:
    a. the member failed or refused to allow Central Standards to carry out an action permissible under s. 99 of the RHPA;
    b. in the opinion of Central Standards, a remedial program is unlikely to be successful;
    c. the member has failed or refused to follow the remedial program recommended or required by Central Standards or by a Subcommittee or comply with a direction made pursuant to ss. 182(4) of the RHPA;
    d. Central Standards determines that there is evidence of misconduct or incompetence on the part of the member such that a remedial program would be inappropriate;
    e. the member has failed to comply with an undertaking given to Central Standards;
    f. in the opinion of Central Standards, the state of the member's health or competency is such that a clear danger to patient safety is perceived to exist.
    g. In the opinion of Central Standards, the member's standard of care may pose a risk to patient safety.

Undertaking

14. Where a member gives an undertaking to Central Standards:
    a. the undertaking shall be deemed to be an undertaking given to CPSM;
    b. a copy of the undertaking must be promptly made available to the Registrar; and
    c. Central Standards shall be responsible for monitoring of the undertaking unless there is a referral of the registrant to the Registrar pursuant to this Bylaw.

15. Receipt of a copy of an undertaking pursuant to this section shall not be deemed to be a referral of a matter to the Registrar.

16. The failure of a registrant without reasonable excuse to comply with an undertaking constitutes professional misconduct.

Referral to Another Regulatory Body

17.
    a. If a Committee Member who is a member of a regulated health profession other than medicine certifies that the circumstances of a matter before Central Standards or a Subcommittee fall within his/her Mandatory Reporting Obligation, the concern must be referred to the Registrar for referral to the regulatory authority responsible for the practice of that regulated health profession in Manitoba.
    b. In the absence of a Mandatory Reporting Obligation, Central Standards may refer a concern about a member of another regulated health profession to the Registrar for referral to the regulatory authority responsible for the practice of that regulated health profession in Manitoba in the following circumstances:
        i. Central Standards has concerns of possible misconduct or incompetence on the part of the individual;
        ii. Central Standards considers the state of an individual's health or competency may be a danger to the public; or
        iii. Central Standards considers a matter relating to that individual may be of concern to another regulatory body.

18. Section 18 applies with necessary changes in points of detail to a WRHA Standards Committee.

19. Where a registrant acquires information through participation in a Critical Incident Review Committee respecting a matter that is reportable to CPSM pursuant to the Code of Ethics or *The Regulated Health Professions Act*, the registrant must take reasonable steps to ensure that the Critical Incident Review Committee Chair makes a timely report to CPSM.

Confidentiality

20. Except as provided in this Bylaw or in *The Evidence Act*, Central Standards, its Subcommittees and each Committee Member are prohibited from disclosing any record or information that is:
    a. prepared solely for the use of the Committee,
    b. collected, compiled or prepared by the Committee for the purpose of carrying out its duties or,
    c. used solely in the course of or arising out of the Committee proceedings.

21. Disclosure is permissible in the following circumstances:
    a. pursuant to sections 9, 11.a, or 13.b.(ii) of this Bylaw, to a registrant, a Committee, or the administration of a hospital, regional health authority, or other facility where Registrants provide health care services and, if applicable, to the Associate Dean responsible for the trainee, to the extent necessary for the registrant, Committee, administration or Associate Dean to understand or implement recommendations made by Central Standards or a Subcommittee.
    b. pursuant to Section 11.b. of this Bylaw to the Registrar to the extent necessary for the Registrar to understand the concerns of Central Standards or a Subcommittee.
    c. for the purpose of advancing medical research or medical education provided that the disclosure or publication does not identify a registrant or any person whose condition or treatment has been studied, evaluated or investigated.
    d. to another Committee in circumstances the disclosing Committee considers appropriate.
    e. pursuant to Section 11.b or Section 12 of this Bylaw to one or more of:
        i. the administration of a hospital, regional health authority, or other facility where registrants provide health care services,
        ii. the Registrar,
        iii. where the concern involves a member of a regulated health profession other than a member, the regulatory authority responsible for the practice of that regulated health profession in Manitoba,

       as is necessary for the purposes of ensuring patient safety.
    f. as Central Standards deems necessary for the implementation and administration of any program approved by Central Standards.
    g. pursuant to Section 11.d. and Section 15 of this Bylaw, to the Registrar to provide a copy of an undertaking given by a registrant.
    h. to the Executive Committee for the purpose of giving advice pursuant to Section 11.c of this Bylaw.
    i. For the Chair of a Provincial Standards Subcommittee to participate in a WRHA Standards Committee for collaboration in standards work.

22. Sections 11 and 22 of this Bylaw shall apply with necessary changes in points of detail to CPSM registrants who sit as members of a WRHA Standards Committee.

Procedure for Disclosure of Standards Information

23. Where Central Standards intends to disclose Standards records or information pursuant to this Bylaw, it must:
    a. by majority ruling, consent to the disclosure.
    b. specify in its minutes:
        i. its reasons for such disclosure,
        ii. to whom the disclosure may be made, and
        iii. what Standards records or information may be disclosed.
    c. direct the Chair of the Committee to sign a declaration on behalf of the Committee, indicating the Committee's consent to the release of Standards records or information.

Reporting Obligations

24. Subcommittees must make the following reports:
    a. to Central Standards following each Subcommittee meeting, minutes of the meeting, which should include:
        i. name of Subcommittee,
        ii. members in attendance,
        iii. location of meeting,
        iv. date of meeting,
        v. schedule of future meetings,
        vi. summary of business arising and new business,
        vii. particulars of standards activities including:
            a. overview of structured audits,
            b. overview of peer and chart reviews,
            c. educational activities of the medical staff,
            d. future topics and issues for re-review or re-audit, and
            e. other quality initiatives.
    b. to Administration in the applicable facility or facilities included in the subcommittee's work, at least once in each calendar year, without identifying any registrant or patient, a summary of the activities of the subcommittee.
    c. to Central Standards:
        i. a report of inactivity if a Subcommittee has not met for 12 consecutive months.
        ii. any circumstances which the subcommittee believes should result in reporting by Central Standards pursuant to sections 11, 12, 14, 17, or 18 of this Bylaw.

25. Following each meeting, Central Standards must report to Council, without identifying any registrant or patient, a summary of the activities of Central Standards.

26. The Chair of the WRHA Standards Committee must:
    a. report to Central Standards on a semi-annual basis as to the activities of the WRHA Standards Committee and its subcommittees. The report must include, but is not limited to, a summary of each audit of clinical practice that has been completed during the reporting period, particularizing:
        i. the audit tool used,
        ii. the audit results,
        iii. any recommendations made by the WRHA Standards Committee, and
        iv. any actions taken by the WRHA Standards Committee or by the WRHA or facility management with respect to the WRHA Standards Committee's recommendation without identifying any registrant or patient.
    b. submit copies of clinical audits upon the request of Central Standards.

Fees

27. Central Standards may levy a fee, payable by a registrant, for expenses incurred by CPSM in review of that registrant's practice pursuant to this Bylaw.

~~SCHEDULE A – AREA STANDARDS SUBCOMMITTEES~~

~~The Area Standards Subcommittees of the Central Standards Committee are as follows:~~

~~Prairie Mountain Health ASC~~

~~Interlake/Eastern ASC~~

~~Brandon Regional Health Centre ASC~~

~~Selkirk ASC~~

~~Northern ASC~~

~~Southern ASC~~

~~Portage ASC~~

~~SCHEDULE B – HOSPITAL STANDARDS SUBCOMMITTEES~~

~~The Hospital Standards Subcommittees of the Central Standards Committee are as follows:~~

~~Altona Community Memorial Health Centre Standards Committee~~

~~Bethesda Hospital Standards Committee, Steinbach~~

~~Boundary Trails Health Centre Standards Committee~~

~~Carmen Memorial Hospital Standards Committee~~

~~Gladstone Health Centre Standards Committee~~

~~Morris/Emerson Standards Committee~~

~~Ste. Anne Hospital Standards Committee~~

~~St. Claude/Notre-Dame-de-Lourdes/Treherne Standards Committee~~

~~Vita & District Health Centre Standards Committee~~

~~SCHEDULE C – NON-HOSPITAL STANDARDS SUBCOMMITTEES~~

~~Brandon Regional Health Centre Psychiatry Standards Committee~~

~~Eden Mental Health Centre Standards Committee~~

~~Selkirk Mental Health Centre Standards Committee~~

~~SCHEDULE D – PROVINCIAL STANDARDS SUBCOMMITTEES~~

~~The Provincial Standards Subcommittees of the Central Standards Committee are as follows:~~

~~Endoscopy Provincial Standards Committee~~

~~Orthopedic Surgery Provincial Standards Committee~~

~~CancerCare Standards Committee~~

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - DECEMBER 14, 2022

CONSENT AGENDA ITEM

TITLE: Standard of Practice – Withholding and Withdrawing Life Sustaining Treatment

BACKGROUND

CPSM first established requirements of its registrants for withholding and withdrawing life sustaining treatment in a Statement in 2007. With the passing of the RHPA, it became necessary to convert requirements included in Statements that remain relevant to a different format. As such, in 2019, much of the content of the original Statement was incorporated into a Standard of Practice. When that occurred, much of the background information, guiding principles and other content that was not a formal requirement was omitted. Some of that content will be reflected in a companion document, but it has become apparent that changing the wording of the Standard of Practice itself is necessary to address a particular concern raised about the circumstances when the requirements become relevant. In particular, the requirements do not apply to withholding or withdrawing treatment from patients who are dead as per the definition under the *Vital Statistics Act*.

The proposed wording for the Standard of Practice based on consultation with the Chief Medical Officer of Shared Health, Dr. Gray, who brought the concern to the attention of the Registrar, follows. The added words are in red:

> *The Vital Statistics Act, C.C.S.M. c. V60, s. 2. provides that the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs. As such, the requirements of this Standard of Practice do not apply to withholding or withdrawing life-sustaining treatment from a patient whose brain function has irreversibly ceased as that person has already died in accordance with the legal definition of the death of a person.*

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

Clarifying that where a patient is already legally dead, the requirements of this Standard of Practice do not apply will assist in preventing any unnecessary confusion as to when these requirements become relevant. This will assist CPSM registrants in communicating with the loved ones of a patient who has died and will avoid conflict between health care providers and the loved ones of deceased patients during a very difficult time.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the changes to the Standard of Practice – Withholding and Withdrawing Life Sustaining Treatment as attached.

Standard of Practice

Withholding & Withdrawing Life-Sustaining Treatment

Initial Approval: January 1, 2019 **Effective Date: January 1, 2019**

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 registrants 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.

Persons who may be legally authorized to consent to or refuse medical treatment on behalf of a patient include persons:

(a) authorized by statute, including:

(i) a health care proxy appointed by the patient in accordance with *The Health Care Directives Act*, C.C.S.M. c. H27;

(ii) a Committee appointed under *The Mental Health Act*, C.C.S.M c. M110;

(iii) a substituted decision maker appointed under *The Vulnerable Persons Living with a Mental Disability Act*, C.C.S.M c. V90;

(iv) The Public Trustee, in limited circumstances.

(b) recognized by the common law, including:

(i) a parent or other legal guardian of a patient who is a minor;

(ii) a person with authority pursuant to a decision or order of a Court with jurisdiction.

The Vital Statistics Act, C.C.S.M. c. V60, s. 2. provides that the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs. *As such, the requirements of this Standard of Practice do not apply to withholding or withdrawing life-sustaining treatment from a patient whose brain function has irreversibly ceased as that person has already died in accordance with the legal definition of the death of a person.*

Definitions

The following terms are defined for the purpose of this Standard of Practice. **The definitions do not necessarily reflect the meaning of the terms used in other contexts.**

Family
Persons recognized by the patient as being closely linked to the patient in knowledge, care and affection, including biological family, those linked by marriage or common-law (same or opposite sex) and any other person chosen by the patient as his/her family.

Health Care Team
This term includes all personnel who are actively involved in the health care of the patient and to whom the physician may turn for input in accordance with this Standard of Practice.

Life-sustaining Treatment
Any treatment that is undertaken for the purpose of prolonging the patient's life and that is not intended to reverse the underlying medical condition.

Minimum Goal of Life-sustaining Treatment
This term is clinically defined as the maintenance of or recovery to a level of cerebral function that enables the patient to:

- achieve awareness of self; and
- achieve awareness of environment; and
- experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment.

Physician
A registrant of CPSM who is providing medical care to the patient. Where there is more than one physician involved in the patient's medical care, the physician who is the coordinator of the patient's medical care is responsible for ensuring that the requirements of this Standard of Practice are met.

Patient
The patient is the recipient of medical care whose well-being is the physician's primary concern.

Proxy
The person who is legally authorized to make health care decisions on the patient's behalf in circumstances where the patient lacks capacity to make such decisions, including, but not limited to, a health care proxy appointed in a health care directive.

Representative
The person who represents the patient and/or the patient's family in discussions about the patient's health care where the patient lacks capacity to make health care decisions and there is no proxy or it is not possible to communicate with the patient or the proxy for any reason. This person is usually a member of the patient's family. If the patient is in a health care facility, the representative may be determined in accordance with that facility's internal policy. In the absence of an applicable policy, or if the patient is in the community, it will be up to the physician to use his/her best judgment to identify a member of the patient's family who has the support of interested parties to assume this role.

Requirement

When a physician is confronted with a clinical scenario in which withholding or withdrawing life-sustaining treatment is being considered, the four main components of the process the physician must follow are the same in all cases:

1. Clinical Assessment;
2. Communication;
3. Implementation;
4. Documentation.

This Standard of Practice establishes:

- **General Requirements**, which apply to each of the four components described above in all circumstances. These are the only requirements when there is consensus between the patient/proxy/representative and the physician.
- **Specific Requirements**, which supplement and/or modify the General Requirements when consensus cannot be achieved in the following circumstances:
    A. No consensus - the physician offers life-sustaining treatment but the patient/proxy declines treatment or the representative advocates withholding or withdrawing treatment;
    B. No consensus - the minimum goal is not realistically achievable and the physician concludes that life-sustaining treatment should be withheld or withdrawn but the patient/proxy/representative does not agree and/or demands life-sustaining treatment;
    C. No consensus - the minimum goal is achievable but the physician concludes that life-sustaining treatment should be withheld or withdrawn and the patient/proxy/representative does not agree and/or demands life-sustaining treatment;
    D. Emergency Situations where communication between physician and patient/proxy/representative cannot occur;
    E. Cardiac arrest and resuscitation, including Cardiopulmonary resuscitation (CPR) and/or Advanced Cardiac Life Support (ACLS), and Do Not Attempt Resuscitation (DNAR) Orders.

General Requirements

1. Clinical Assessment

- The physician must clinically assess the patient by gathering and evaluating information about the patient's physical condition, diagnosis, prognosis and treatment options, including palliation, balancing the risks and benefits associated with identified treatment options.
- The assessment must be based on the best available clinical evidence, including, where appropriate, consultation with another physician and must include consideration of the feasible life-sustaining treatment options in the context of the minimum goal of life-sustaining treatment, which is clinically defined as:
    - maintenance of or recovery to a level of cerebral function that enables the patient to:
        - achieve awareness of self; and
        - achieve awareness of environment; and
        - experience his/her own existence.

For pediatric patients, the potential for neurological development must be factored into the assessment

- Where the physician is uncertain about any aspect of the assessment, including the range of treatment options, he/she must seek additional clinical input by consulting with at least one other physician before concluding that the minimum goal is not realistically achievable and/or that life-sustaining treatment should be withheld or withdrawn for any other reason.
- Based on the clinical assessment, the physician may conclude that:
    1. Life-sustaining treatment should be offered; OR
    2. Life-sustaining treatment should be withheld or withdrawn because the minimum goal is not realistically achievable.
- Where, based on the clinical assessment, the physician concludes that the minimum goal is realistically achievable, but is contemplating withholding or withdrawing life-sustaining treatment because of concerns that there are likely to be significant negative effects on the patient, including, but not limited to pain and suffering, the physician should explore the patient's values, needs, goals and expectations of treatment with the patient/proxy/representative before concluding that life-sustaining treatment should be withheld or withdrawn.

2. Communication

- The physician must identify the person(s) with whom he/she must communicate about withholding or withdrawing life-sustaining treatment and communicate with that person as early as possible and, where possible before life-sustaining treatment is withheld or withdrawn.

- Every effort must be made to communicate with the patient as early as possible, while the patient can identify his/her preferences for treatment and has the capacity to make his/her own health care decisions.
- Where there is a proxy, the physician must share personal health information and consult with the proxy in the same manner he/she would otherwise consult with the patient, unless he/she is made aware of limits on the proxy's authority.
- Where there is no proxy, the physician must share personal health information and consult with the representative in accordance with this Standard of Practice to identify known preferences and/or interests of the patient and/or what treatment might be in the patient's best interests.
- The physician must comply with reasonable requests of the patient, proxy or representative to include other person(s) in the discussion described below.
- The physician must ensure that relevant information is exchanged and strive for understanding and consensus when discussing withholding or withdrawing life-sustaining treatment from the patient. The nature and content of discussion will depend on the physician's assessment of treatment options and the individual circumstances of the patient. The discussion should, at a minimum, include:
  - a description of the underlying condition or ailment and prognosis;
  - an exploration of the patient's values, needs, goals and expectations of treatment;
  - the options for treatment and their expected outcome, including potential benefit and harm;
  - where the physician has concluded that treatment should be withheld or withdrawn, an explanation of the assessment and the basis for this conclusion;
  - assurances that the patient will not be abandoned if treatment is either withheld or withdrawn, including an explanation and offer of palliative care;
  - where there is a need or a request for additional assistance with psychosocial, cultural, spiritual, and/or informational needs by the patient or proxy or representative and/or family, an offer to seek support from institutional resources such as social work, chaplaincy, or clinical ethics;
  - where welcomed by the patient, proxy or representative, the patient's personal, cultural, religious and family issues insofar as they are relevant to the decision;
  - where appropriate, an exploration of potential guilt or regret associated with end of life decision-making.

3. Implementation

- Treatment may be withheld or withdrawn where there is consensus between the physician and:
  1. a patient who is capable of making his/her own health care decisions; or
  2. the proxy or representative, where the patient lacks capacity to make his/her own health care decisions.

- Provided that the physician has complied with the requirements of this Standard of Practice, decisions may be implemented in as timely a manner as possible, while respecting the grieving process for patients and families.
- Once a decision to withhold or withdraw treatment is made, the need for someone to communicate this decision to other family members who were not involved in making the decision should be explored. In such circumstances, with proper consent, the physician should be prepared to assist by providing appropriate information to such family members.

4. Documentation

- Accurate and complete documentation of the pertinent details of the physician's assessment and his/her interaction with the patient and others involved in decisions whether to withhold or withdraw life-sustaining treatment is essential.
- At a minimum, the physician must clearly record in the patient's health care record:
  - sufficient details about the assessment of treatment options to identify the basis for the conclusion that treatment should be withheld or withdrawn;
  - pertinent details regarding consultations with others and second opinions;
  - if it is determined that the patient lacks capacity to make his/her own health care decisions, the basis for that determination and the identity of the proxy or representative designated in accordance with this Practice Direction;
  - particulars of the communications required by this Practice Direction, including:
    - identity of the participants in the discussion;
    - where there is a proxy or representative, any limits on that person's authority to make decisions on the patient's behalf;
    - relevant information communicated by the physician;
    - concerns raised by others and the information provided by the physician in response;
    - whether or not consensus was reached;
    - where consensus was not reached, the nature of the efforts made to reach consensus;
    - the implementation plan.

Specific Requirements

The specific requirements for the circumstances identified earlier are set out in separate sections below. Where no specific requirements are identified, the general requirements apply. Where specific requirements are identified, those requirements supplement or modify the general requirements.

1. No Consensus – The physician offers life-sustaining treatment but the patient/proxy declines treatment or the representative advocates withholding or withdrawing treatment

1.1. **Clinical Assessment**

- Where the physician is confronted with a patient who declines life-sustaining treatment that is offered, that physician should consider taking additional steps to assess the patient's capacity to make his/her own health care decisions.

1.2. **Communication**

- Where a patient with capacity to make his/her own health care decisions or a legally authorized proxy declines life-sustaining treatment for that patient, the physician must be satisfied that the decision to decline treatment is informed and voluntary in that the nature of treatment, including its benefits and risks and alternatives, are understood.
- Where the patient lacks capacity and the decision to decline treatment is made by a proxy on behalf of the patient, the physician must be satisfied that the proxy's legal authority includes declining treatment on the patient's behalf in such circumstances.
- Where the patient lacks capacity, there is no proxy, and a representative advocates withholding or withdrawing life-sustaining treatment:
  - the physician should review with the representative the physician's concerns regarding that person's lack of legal authority to make such a decision on the patient's behalf and the representative's reasons for advocating withholding or withdrawing life-sustaining treatment; and
  - should consider looking to other members of the health care team and/or another physician as a source of information.
- The physician must be mindful of the general communication requirements, but should be prepared to meet the unique needs of the patient, particularly in respect to the physician's communication with the patient's family

1.3. **Implementation**

- If the physician has satisfied him/herself of the matters referred to in the Communication section above, he/she **must** withhold or withdraw treatment in accordance with the patient/proxy's wishes.
- If a representative is advocating withholding or withdrawing treatment against the recommendation of the physician that the treatment be provided, the physician must make his/her treatment decisions in accordance with the accepted standard of care.

1.4. **Documentation**

- There are no specific requirements; the general requirements apply.

2. No Consensus – The minimum goal is not realistically achievable and the physician concludes that life-sustaining treatment should be withheld or withdrawn but the patient/proxy/representative does not agree and/or demands life-sustaining treatment

2.1. Clinical Assessment

- There are no specific requirements; the general requirements apply.

2.2. Communication

- Where a physician concludes that the minimum goal is not realistically achievable and that life-sustaining treatment should be withheld or withdrawn and there is no consensus with the patient/proxy/representative, the physician is not obligated to continue to try to reach a consensus before withholding or withdrawing treatment, but must meet the implementation requirements set out below before treatment can be withheld or withdrawn.

2.3. Implementation

- WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS NOT REALISTICALLY ACHIEVABLE AND THERE IS NO CONSENSUS, IF POSSIBLE, that physician must consult with another physician:
  1. Where the consultation supports the opposite conclusion, that the minimum goal is realistically achievable, the physician who sought the consultation must either provide the treatment or facilitate the transfer of care to another physician who will provide the treatment.
  2. Where the consultation supports the conclusion that the minimum goal is not realistically achievable, or it is not possible to consult with another physician, the physician who sought the consultation is not obligated to continue to try to reach consensus before withholding or withdrawing treatment, but must first advise the patient/proxy/representative:
     a. that the consultation supports that physician's assessment that the minimum goal is not realistically achievable, or that it was not possible to consult with another physician and attempt to address any remaining concerns; and
     b. of the specified location, date and time at which treatment will be withheld or withdrawn.

2.4. Documentation

- The information regarding the communication between the physician and the patient/proxy/representative following the physician's consultation with the other physician, including the specified location, date and time at which treatment will be withheld or withdrawn, must be documented in the patient's chart.

3. No Consensus – The minimum goal is achievable, but the physician concludes that life-sustaining treatment should be withheld or withdrawn, and the patient/proxy/ representative does not agree and/or demands life-sustaining treatment

3.1. Clinical Assessment

- There are no specific requirements; the general requirements apply.

3.2. Communication

- In this situation, communication is particularly challenging and important. The physician should be aware that careful discussion above and beyond what is generally required may be necessary;
- The concerns in these circumstances may not relate to clinical assessment or care and may involve subjective values and judgments regarding quality of life;
- When confronted with such concerns, the physician should consider seeking assistance from other members of the health care team and/or religious authorities and/or ethics and/or other consultants.

3.3. Implementation

- WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS REALISTICALLY ACHIEVABLE BUT THAT TREATMENT SHOULD BE WITHHELD OR WITHDRAWN, that physician must consult with another physician.
    1. Where the consultation supports the opposite conclusion, that treatment should not be withheld or withdrawn, the physician who sought the consultation must either provide the treatment or facilitate transfer of care to another physician who will provide the treatment.
    2. Where the consultation supports the conclusion that treatment should be withheld or withdrawn:
        a. The physician who sought the consultation must advise the patient/proxy/representative that the consultation supports the initial assessment that treatment should be withheld or withdrawn
        b. If there is still a demand or request for treatment, the physician must attempt to address the reasons directly and with a view to reaching consensus. The physician should consider resolving the conflict by:
            i. offering a time-limited trial of treatment with a clearly defined outcome; and/or
            ii. involving additional or alternative methods to facilitate a consensus, including, but not limited to, available resources such as a patient advocate, mediator or ethics or institutional review processes.
        c. If consensus cannot be reached, the physician must give the patient/proxy/representative a reasonable opportunity to identify another physician who is willing to assume care of the patient and

must facilitate the transfer of care and provide all relevant medical information to that physician.

d. Where, despite all reasonable efforts, consensus cannot be reached the physician may withhold or withdraw life-sustaining treatment, but:
    i. in the case of a patient/proxy who is still not in agreement with the decision to withhold or withdraw treatment, the physician must provide at least 96 hours advance notice to the patient or proxy as described below.

3.4. Written Notice

The notice must be in writing, where possible, and must contain, at a minimum:

- name and location of the patient;
- name of the person to whom notice has been given;
- name, address and telephone number of the physician;
- diagnosis;
- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- date and time that notice was provided;
- name of the person who provided the notice.

3.5. Verbal Notice

Where it is not possible to provide notice in writing, notice to withhold or withdraw treatment may be given verbally, but must be witnessed and include:

- name and location of the patient;
- name, address and telephone number of the physician;
- diagnosis;
- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- name of the person who provided the notice.
    i. in the case of a representative who is still not in agreement with the decision to withhold or withdraw treatment, the physician should exercise his/her discretion as to what, if any, notice should be provided to the representative before treatment is withheld or withdrawn.

3.6. Documentation

- In addition to the general requirements of documentation, the following must also be documented:
    - Where written notice has been given, a copy of the notice;
    - Where verbal notice has been given:
        - the reason that it was not possible to provide written notice;

- all of the information required when verbal notice is given (see above);
- the signature of the physician and a witness to the notice.

4. Emergency situations where communication between physician and patient/proxy/representative cannot occur

4.1. Clinical Assessment

- In emergent situations, where the patient lacks capacity to make his/her own health care decisions and it is not reasonably possible to identify and communicate with a proxy/representative, the physician must make a rapid assessment based on the patient's clinical status as well as information from others who have interacted with the patient, including other involved members of the health care team, before deciding whether to withhold or withdraw life-sustaining treatment.

4.2. Communication

- The physician should communicate with the proxy/representative as soon as possible after the decision has been implemented.

4.3. Implementation

- The physician must decide when to withhold or withdraw life-sustaining treatment.

4.4. Documentation

- There are no specific requirements; the general requirements apply.

5. Cardiac arrest and resuscitation, cardiopulmonary resuscitation (CPR) and/or advanced cardiac life-support (ACLS), and do not attempt resuscitation (DNAR) orders

Situations involving cardiac arrest are unique because, unlike some potentially life-sustaining treatments which can be provided over a prolonged period of time, CPR and/or ACLS are interim measures implemented to achieve a return of spontaneous circulation.

Actual or impending cardiac arrest is very different from a situation where a DNAR order is being considered as a proactive element of advanced care planning. The specific requirements of physicians in each of these situations are addressed separately in this Practice Direction.

The requirements for Clinical Assessment, Communication, Implementation and Documentation are combined in this section.

5.1. Actual or Impending Cardiac Arrest and Resuscitation

- Actual or impending cardiac arrest often occurs unexpectedly and it is not possible to communicate and/or achieve consensus before either initiating or withholding resuscitative efforts.
- A physician is not required to initiate or continue CPR and/or ACLS, if, based on his/her clinical assessment, the physician determines that:
  - CPR/ACLS will not achieve return of spontaneous circulation; OR
  - resuscitation will not result in the patient achieving the minimum goal.

If the physician is uncertain about his/her clinical assessment, he/she must consult with another physician, where possible.

- In the setting of an impending cardiac arrest, where a physician determines that he/she will not initiate cardiac resuscitation based on one of these criteria, and it is possible to communicate the decision prior to the cardiac arrest, the physician will make reasonable efforts to communicate the decision to the patient, proxy or representative, and will document the discussion in the patient's medical record and write an DNAR order.

5.2. DNR Orders

- Where a physician determines that a DNAR order is appropriate, but cardiac arrest is not imminent/impending, that physician must identify the appropriate section in this Practice Direction which corresponds to the surrounding circumstances and attempt to meet the requirements of that section prior to writing a DNAR Order. If while attempting to meet the requirements of the appropriate section(s), the patient suffers a cardiac arrest or the physician determines that a cardiac arrest in imminent/impending, the requirements automatically change to those for Actual or Impending Cardiac Arrest and Resuscitation as set out above.

Legal Intervention

If at any time a physician becomes aware of anything such as a legal proceeding and/or a Court Order that may impact the legal right of a patient, proxy or representative to request or demand specific treatment(s), that physician must take steps to ensure that he/she complies with the law and should consider seeking legal advice.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - DECEMBER 14, 2022

FOR INFORMATION

TITLE: Prescribing Rules Review

BACKGROUND

A review of the prescribing rules is a strategic organizational priority set by Council. It is undertaken jointly with the Colleges of Pharmacists and Registered Nurses.

CPSM has been arranging monthly meetings of the Prescribing Rules Working Group chaired by Dr. Shenouda to review prescribing related documents. These meetings have involved several CPSM Registrants and staff members of both CPSM and the tow other regulatory colleges. The review is rather expansive given the breadth of prescribing and also the input required from the other professions involved in prescribing, especially pharmacists.

All matters are reviewed through the lens of ensuring and increasing access to prescribed medicines, patient safety, and risk to the patients and public. All matters are also reviewed with a lens from northern remote communities, disadvantaged patients, and addictions medicine. The Working Group is fortunate to have several medical practitioners that practice in these areas and communities.

To date, all matters reviewed are with respect to prescribing in the community, not the ordering of medication in hospitals or other health institutions.

Issues Reviewed to Date

To date, the Prescribing Rules Working Group has reviewed the following items:

1. Tramadol and Tramacet
2. M3P Continuation
3. Section 56 Exemption
4. Practice Direction - Verbal Orders for M3P (in Limited Circumstances and Amendments to CPSM General Regulation – detailed M3P Requirements)
5. Standard of Practice - Prescribing Requirements
6. Transmission of Prescriptions – Electronic, Virtual, and Verbal

This Briefing Note explains these above items. The inclusion of Tramadol/Tramacet has already been included on the M3P list of drugs. The remaining five items are in various stages of completion, with some that can be ready for implementation. However, the Prescribing Rules Working Group recommends that these and other changes in prescribing all be implemented at the same time to enable the five professions to properly address the change management that will be required. Rather than the prescribing rules change staggered one at a time over a period of a year, it is recommended that all the changes be made at once so that the professions are aware and have to make the various changes all at once.

At this stage we are also considering possibly a complete re-organizing of almost all prescribing documents into one standard of practice. Currently the prescribing rules are fragmented through various documents. For ease of reference, one document could be the go-to source for all prescribing rules – general prescribing rules, transmission, M3P, etc. There are currently 8 Practice Directions and one Standard of Practice, with much duplication. It would be helpful to have input from Council on this matter.

Issues Still to be Reviewed

The following issues are yet to be reviewed by the Prescribing Rules Working Group:

1. Enhanced prescribing for clinical assistants, physician assistants, and residents
2. Practice Direction - Dispensing Physicians
3. Practice Direction – Rural, Remote, and Underserved Populations; Access to Prescribed Medications
4. Regulations on Prescribing
5. Prescribing Rules for Community vs Hospitals/PCHs/Health Centres
6. Practice Direction – Physician/Pharmacist Relationship
7. Anything else decided by the Working Group

Part 1 - Tramadol and Tramacet

Councils of both the Colleges of Pharmacy and Physicians/Surgeons determine which drugs are subject to the prescribing rules outlined in the Manitoba Prescribing Practices Program (M3P program). These drugs are known as M3P drugs and are listed on the M3P drug list, which is attached to the M3P Practice Direction.

Tramadol and Tramacet were recently reclassified under the Controlled Drugs and Substances Act due to their high potential for abuse and were given a more restricted use and distribution.

In March 2022 councils of both the Pharmacists and Physicians & Surgeons approved including Tramadol products and preparations on the M3P schedule of drugs.

This was listed as an item for the Prescribing Rules Working Group to consider under its Terms of Reference but was addressed just prior to the Working Group being convened. It is being included here for completeness.

Part 2 - M3P Continuation and Revision

The Working Group considered whether the M3P should be included. Also considered was the potential change and/or elimination of the M3P Program as well as the format by which M3P prescription could be transmitted. The Prescribing Rules Working Group agreed that:

A) The M3P program be continued, with the physical/printed M3P booklets to be phased out, with the ability for M3P prescriptions to be handwritten if required. The importance of distinguishing M3P drugs from other drugs due to their potential for abuse and societal risk was seen to be of continuing importance.

B) M3P prescriptions be permitted to be either sent by facsimile or be provided in handwritten format to a patient. This was subsequently included in a discussion on the Joint Practice Direction entitled the "Electronic Transmission of Prescriptions". The Prescribing Rules Working Group is determining if the M3P prescriptions can be transmitted electronically (by email), and if so, what impact this would have on the M3P program.

Although there are funds allocated by the provincial Government for the administration of the M3P program, it was determined that the amount of money for the actual printing of the M3P forms is fairly minimal and the College of Pharmacists would retain most money for the tracking of these drugs it performs for Government.

M3P Program- Changes to the "authorization" process

Background

Since the inception of the M3P program, an informal agreement between CPSM and CPhM Registrars required that CPSM "confirm" to CPhM that a physician has no prescribing restrictions. This

confirmation was done formally, in writing, and was prompted by a physician requesting that CPhM print their first order of M3P prescription pads. From a practical perspective, this confirmed to CPhM that a physician had no restrictions preventing them from prescribing M3P drugs at the time of the physician's request.

Due to this formerly existing process, some physicians were also erroneously under the impression that this process was a mechanism to obtain approval from the CPSM Registrar to prescribe M3P medications. Refusing to confirm that a physician was able to prescribe M3P drugs (and other medications) is only done under **extremely rare** circumstances. The former process was thus created for the purpose of identifying an extremely small number of physicians with prescribing restrictions. Currently, only **four fully licensed physicians have prescribing restrictions.**

Summary

The Registrars of CPSM and CPhM agreed that there was an opportunity to streamline the current process while both ensuring patient safety as well as the efficient allocation of regulatory resources. An updated process, in line with right touch regulation, and to more effectively allocate both CPSM and CPhM regulatory resources was discussed, and it was agreed that the current process of a physician obtaining M3P prescription pads from CPhM be abolished.

Therefore, all Manitoba physicians will now be able to appropriately prescribe medications on the M3P drug list, provided it is within their scope of practice. A newsletter update will be sent to all physicians (and pharmacists) to inform them of this upcoming change.

Description of New Process and Immediate Impact

An updated list of physicians with prescribing restrictions, will be posted in CPhM 's secure member portal and updated on a regular basis. This will allow pharmacists to determine if a physician has any prescribing restrictions. Implementing this process may also assist in the detection of prescription forgeries, in cases where a prescription forgery may be written under a physician who has prescribing restrictions.

This list will exclude physicians who are suspended or have had their CPSM license cancelled. These notices will continue to be provided separately to CPhM by CPSM's Complaints and Investigations Department. No input from Councils is required for this change to be effective.

Part 3 – Section 56 Exemption

Background

At the onset of the COVID-19 pandemic in March 2020, Health Canada announced federal exemptions under subsection 56(1) of the *Controlled Drugs and Substances Act* (CDSA) and its Regulations for patients, practitioners and pharmacists regarding the prescribing and provision of controlled substances in Canada. The exemptions were implemented (at a federal level) during the pandemic to maintain Canadians' access to narcotic and controlled substances for necessary medical treatments (e.g., treatment of substance use disorders and chronic pain).

Health Canada recently announced that the federal exemption will remain in effect until **September 30, 2026**, demonstrating the ongoing need to prevent delays and interruptions in patient care, in addition to permitting CDSA prescription transfers across provinces.

This federal exemption applies to several sections in federal legislation and, if implemented in its entirety would:

A) Permit Pharmacists to extend or renew existing prescriptions.
B) Permit pharmacists to transfer prescriptions to other pharmacies.
C) Permit practitioners to verbally prescribe prescriptions with controlled substances
D) Allow an individual (e.g., pharmacy employee/technician, courier or individual requested by the patient, etc.) to deliver controlled substances to patients (at their homes or an alternate location).
E) Permit pharmacists to adapt prescriptions for controlled substances (adjust the formulation, dose and regimen, de-prescribe) AND provide part-fills of a controlled substance which is less than the total amount of the drug specified by a practitioner.

Although these exemptions were implemented by the Federal Government, provincial regulators must notify their Registrants before they can be enacted. Since provincial legislation differs by jurisdiction, not all exemptions are currently implemented in all provinces. In Manitoba, one barrier to implementation is regulation amendment, which is a lengthy process requiring both public and registrant consultations, with a final approval from Cabinet. Specifically, legislation around the M3P is a barrier to implementing several Section 56 (1) exemptions. Both CPSM and CPhM have raised this with government in the past to no avail.

At the onset of the COVID-19 pandemic, CPSM, CPhM, and CRNM jointly introduced interim measures that expanded the available methods of transmission for M3P prescriptions. This has enhanced safe access in personal care homes/long term care settings and for palliative care patients in the community through permitting verbal orders.

For clarity, this applies to the following categories of medications:

I) CDSA and FDR medications that fall under the M3P program.
II) CDSA and FDR medications that are NOT part of the M3P program (this is a very small subset of drugs). Commonly used medications in this category include Tylenol #2, Tylenol #3, Cotridin, Concerta, Biphentin, Vyvanse.
III) Benzodiazepines and other targeted substances.

Recommendations from CPhM and CPSM Staff

Staff from both colleges met to review in detail the issues relating to the section 56 exemptions and develop recommendations. Each issue raised by section 56(1) exemption were considered by the Prescribing Rules WG. The Prescribing Rules WG also considered whether there were any pressing regulatory concerns/issues that resulted from the subsection 56(1) exemptions, or unintended consequences.

CPhM reviewed an environmental scan from the National Association of Pharmacy Regulatory Authorities, and it was discussed that pretty much most provinces other than Manitoba have formally implemented several section 56(1) exemptions.

Prescribing Rules Working Group Decisions

A -Permit Pharmacists to extend or renew prescriptions. **The Prescribing Rules Working Group recommends that this exemption NOT be implemented.**

> Legislative Considerations- Pharmacists can renew prescriptions for benzodiazepines and other targeted substances, but not for M3P drugs - a regulation change would be required for M3P drugs. This required change is because pharmacists are not classified as "authorized practitioners" under federal legislation, and therefore are unable to prescribe, renew or extend M3P prescriptions under provincial M3P legislation. Concerns were also raised that patients may seek prescriptions from pharmacists rather than from the original prescriber.

B - Permit pharmacists to transfer prescriptions to other pharmacies out of province. CPhM shared a PHIA opinion that the minimum amount of necessary patient information be shared between prescriber and pharmacist when a prescription is transferred (specifically for out of province transfers). CPSM and CPhM agreed that pharmacists may share additional information (i.e., name/phone number of the pharmacy receiving the transfer) where there exists patient safety concerns.

> **It was recommended that this exemption be implemented,** with the requirement for a pharmacist to notify a prescriber simply that an out of province transfer is completed, to help ensure continuity of care. A prescriber could, at their discretion, contact a pharmacy for additional information in the interest of patient safety. It will be specified in guidance to healthcare professionals that additional information can be disclosed on a case-by-case basis. This is seen to be important for access to prescribed medicine and can be performed safely.
>
> Legislative Considerations- none

C - Permit Practitioners to verbally prescribe prescriptions with controlled substances. **The Prescribing Rules Working Group recommends this exemption proceed, and thereby allow verbal order for all medications,**

under limited circumstances. A consensus was reached that this should be a last resort/emergent option for all patients. This is addressed in the next Part in this document.

IV) Legislative Considerations**-** While Regulation amendments would be best for *Controlled Drugs and Substances Act* and *Food and Drug Act Regulations* medications that fall under the M3P program, this could be implemented under the current *CPSM General Regulations*. These amendments are discussed in the next part.

D - Allow an individual to deliver controlled substances to patients. Guidance was provided in 2020 by CPhM which already permits this. In essence, this permits a courier, whether specific to the pharmacy or commercial, to deliver controlled substances to the patient. **The Prescribing Rules Working Group recommended that no further action be taken.**

Legislative Considerations- none; this is already permitted in Manitoba.

E - Permit Pharmacists to adapt prescriptions for controlled substances (adjust the formulation, dose/regimen, de-prescribe) AND provide part-fills of a controlled substance which is less than the total amount of the drug specified by a practitioner. **The Prescribing Rules Working Group recommended to not implement this exemption.** At this point, this was seen to be outside the scope of the Working Group and had broader implications.

Legislative Considerations- Regulation amendments would be required to adapt formulation, dose/regimen, to deprescribe and to provide part-fills of all M3P medications. In addition, a regulation amendment is required to deprescribe **any** medication.

Part 4 - Practice Direction - Verbal Orders for M3P (in Limited Circumstances and Amendments to CPSM General Regulation – detailed M3P Requirements)

Verbal orders are permitted for many medications in Manitoba. However, medications on the M3P drug list and certain other groups of CDSA medications cannot be prescribed via a verbal order. Under the section 56(1) Federal Exemptions, CDSA medications that do not appear on the M3P drug list can become eligible for verbal orders.

The CPSM Prescribing Rules Working Group has recommended that verbal orders be permitted for all medications (including M3P medications). Verbal orders are currently not permitted for certain medications, including all medications on the M3P drug list.

The Working Group also directed Colleges' Staff to determine if verbal prescribing of M3P prescriptions in the community may occur in compliance with the law. These verbal prescriptions would only be permitted under very limited circumstances when timely fax or electronic transmission of a prescription is not possible **and** this may lead to a delay in access to urgently needed medication

for a Manitoba patient. It is NOT intended to be a workaround to the normal requirements for prescribing M3P drugs. All other provinces except for Newfoundland & Labrador permit verbal prescribing of M3P-type drugs (note that the M3P program is Manitoba legislation and as such is unique).

Verbal orders will permit prescribing in situation and/or locations where access to electronic transmission equipment is impossible or impractical. This may include situations where a physician is in a remote location, while they are travelling, or after-hours when clinic facilities or other computers are unavailable. This will greatly increase patient access to medical care and medications.

ISSUE:

The law from the *CPSM General Regulation* requires that any drugs listed on the M3P schedule must be prescribed on an approved form and meet certain requirements.

> *Prescribing M3P schedule drugs*
> *5.8(1) A member who is authorized under the Controlled Drugs and Substances Act (Canada) to prescribe the drugs listed on the M3P schedule must*
> *(a) use an approved form to issue the prescription; and*
> *(b) prescribe only one drug on each form.*
> *5.8(2) The prescription must*
> *(a) include the patient's name, address, date of birth and personal health information number on the approved form;*
> *(b) clearly and accurately set out the name and dosage form of the drug, the quantity to be dispensed, and the directions for use, including the intervals at which the drug is to be taken; and*
> *(c) be dated and signed by the member. (CPSM General Regulation)*

While an amendment to the regulation would be best way to implement such changes, a regulation change would require approval by Cabinet, and may not be imminent.

ANALYSIS AND RESOLUTION:

Immediate Solution:

Initial review focused on the requirement to write the prescription on an approved form. This appeared to be insurmountable.

However, we shifted our focus to another phrasing in the regulation which was “drugs listed on the M3P schedule”. In certain circumstances could the drugs be de-listed or removed from the M3P Schedule? Or is it possible to exempt drugs that are on the schedule in very limited circumstances: i.e., under very limited circumstances when timely fax or electronic transmission of a prescription is

not possible **and** this may lead to a delay in access to urgently needed medication for a Manitoba patient?

CPSM lawyers have advised this can be achieved. In other words, if prescribing under very limited circumstances when timely fax or electronic transmission of a prescription is not possible **and** this may lead to a delay in access to urgently needed medication for a patient, then the drug is not included in the Schedule of M3P drugs. This can be done by, in essence, de-listing the drug in very limited circumstances in each of the CPSM and M3P Practice Directions and Schedules, and those of CPhM.

The M3P Practice Direction already has exemptions that are not strictly consistent with section 5.8 of the CPSM General Regulation:

> 7. This Practice Direction does not apply to:
>
> > 7.1. prescriptions for drugs administered in a personal care home as described under the Manitoba Health Services Insurance Act,
> >
> > 7.2. prescriptions for drugs administered in a hospital,
> >
> > 7.3. the direct administration of a designated drug to a patient by a prescriber.

This list of exemptions may be expanded to include further exemptions.

Long Term Solution:

Ultimately, one must consider why the regulation includes this detail. A quick jurisdictional scan of Ontario and the Western provinces reveals that Manitoba is unique in the detail that is listed for a monitored drug program prescription. In fact, some provinces have no regulations establishing their drug monitoring programs.

As self-regulating professions, CPSM and CPhM are in the best position to know what will best promote patient safety and what is practically feasible in everyday medical and pharmacy practices. CPSM and CPhM discharge their regulatory responsibilities in the public interest. As items change due to the pandemic or due to technology changes (ability to electronically transmit prescriptions directly to pharmacies), having the flexibility to alter this by Councils rather than Cabinet is important.

At the outset of the pandemic to minimize public health risks, CPSM and CPhM issued a joint statement to permit the faxing of M3P prescriptions directly to the pharmacy of the patient's choice, rather than the prescriber handing the physical paper prescription to the patient. Two and a half years later, this emergency, yet antiquated, interim measure is still being utilized.

Eliminating the detailed requirements for the M3P program will permit the Councils of the two regulatory bodies to establish requirements that are timely and meaningful, protect patient safety, and are workable in medical clinics (including virtual practice) and pharmacies.

RECOMMENDATIONS:

1. The M3P Practice Direction be amended to include a section on Verbal Orders:

   Verbal orders for M3P medications may be provided upon the conditions that the prescriber must;

   I) Verbally notify the pharmacist that the verbal order is required as timely fax or electronic transmission of a prescription is not possible **and** the medication is urgently needed by a Manitoba patient.
   II) Clearly communicate the verbal order directly to the pharmacist[1], including all the information required for an M3P prescription.
   III) Ask the pharmacist to verbally read the prescription back to the prescriber to ensure accuracy and patient safety.
   IV) Fax or electronically transmit the same M3P prescription which was provided via a verbal order to the pharmacist. This must be done as soon as reasonably possible.
   V) Indicate the following on the faxed electronic prescription "This prescription was previously provided as a verbal order".
   VI) When making a verbal order for M3P drugs, the registrant must ensure that all requirements of the prescription required in section 6 (except the signature in section 6.7) are repeated back to the registrant by the pharmacist.
   VII) This exemption is to be **used sparingly, in very limited circumstances when timely fax or electronic transmission of a prescription is not possible and may otherwise lead to a delay in access to urgently needed medication for a patient.** This is not to be used as a routine workaround to the usual M3P process.

2. Revise various other Practice Directions which are now under review, if necessary, to ensure that there are no impediments to the verbal orders now.

3. Request that Government amend section 5.8 of the *CPSM General Regulation*. Particularly, revoking details of the M3P requirements and permit the Councils of the Colleges of Pharmacists /Physicians & Surgeons of Manitoba to establish the appropriate regulatory oversight for M3P prescribing. Regulations under the Manitoba Pharmaceutical Act will also require review to determine if similar amendments would be required.

This is section 5.8 of the *CPSM General Regulation*:

Prescribing M3P schedule drugs

[1] This requirement cannot be sufficiently satisfied by a prescriber leaving a voice message. If a voice message is left by a prescriber, a direct callback number must be included to facilitate the pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a pharmacist speaks directly with the prescriber to verify the order.

5.8(1) A member who is authorized under the Controlled Drugs and Substances Act (Canada) to prescribe the drugs listed on the M3P schedule must (a) use an approved form to issue the prescription; and (b) prescribe only one drug on each form.

5.8(2) The prescription must (a) include the patient's name, address, date of birth and personal health information number on the approved form; (b) clearly and accurately set out the name and dosage form of the drug, the quantity to be dispensed, and the directions for use, including the intervals at which the drug is to be taken; and (c) be dated and signed by the member.

5.8(3) Subject to the regulations under the Controlled Drugs and Substances Act (Canada) and section 5.12 of this regulation, physician assistants and clinical assistants are not authorized to prescribe drugs listed on the M3P schedule

Recommended Regulation Amendment

This is the recommended amendment for section 5.8 of the *CPSM General Regulation* (i.e., replace the above with this):

5.8(1) A member who is authorized under the Controlled Drugs and Substances Act (Canada) to prescribe the drugs listed on the M3P schedule must use the prescription formats approved by the council of the College of Physicians and Surgeons of Manitoba and the council of the College of Pharmacists of Manitoba.

5.8(2) Subject to the regulations under the *Controlled Drugs and Substances Act (Canada)* and section 5.12 of this regulation, physician assistants and clinical assistants are not authorized to prescribe drugs listed on the M3P schedule. [Note – Still to be determined whether this is to be included or not. It will be discussed when we get to the PAs and CAs discussion.]

Part 5 – Standard of Practice – Prescribing Requirements

The Prescribing Rules Working Group reviewed the Standard of Practice entitled “Prescribing Requirements” and various revisions were incorporated. The main changes are:

A) Method to contact the prescriber was added.
B) Including the name and telephone number of both the associate Registrant and the supervising physician was added.
C) The section entitled “Verbal Prescriptions” was removed. Verbal prescriptions will be addressed in a separate document.
D) A general Re-write to make it more applicable to today’s environment.

Attached is the revised draft Standard of Practice.

Standard of Practice

Prescribing Requirements

DRAFT

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.

1. Before Prescribing

1.1. Prescribers **must** only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

1.2. Before prescribing a drug, prescribers **must**:

1.1.1. complete an appropriate clinical assessment of the patient;[2]

1.1.2. consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and

1.1.3. obtain informed consent.

[2] Limited exceptions are:

- Having reasonable grounds to believe that the person who conducted the initial assessment had the appropriate knowledge, skill, and judgment to do so and prescriber themselves evaluating the assessment and judging it to be appropriate (eg, true group practices or call groups);
- Prescribing for the sexual partner of a patient with a sexually transmitted infection;
- Prescribing as prophylaxis as part of a Public Health program, including Naloxone;
- Prescribing in an academic teaching environment.

2. Content of Prescriptions

2.1. Prescribers **must** ensure that the following information is included on every written or electronic prescription:

2.1.1. the prescriber's printed name, signature[3] practice address, and CPSM registration number;

2.1.2. method to contact the prescriber- telephone number[4], email address or facsimile number

2.1.3. treatment goal and/or diagnosis/clinical indication(s);

2.1.4. the patient's name and either date of birth or PHIN;

2.1.5. the name of the drug;

2.1.6. the drug strength, quantity, and formulation (tablet, liquid, patch);

2.1.7. the directions for use;

2.1.8. the full date the prescription was issued (day, month, and year);

2.1.9. refill instructions, including dispensing intervals, if applicable.

2.2. Prescribers **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (eg., the patient's weight or date of birth where this information would affect dosage).

2.3. If the prescriber is an associate registrant (Clinical Assistant, Physician Assistant, or Resident), the name and telephone number of both the associate Registrant and the supervising physician must be included on every prescription.

3. Format of Prescriptions

3.1. Prescriptions may be in these formats: handwritten (legibly), electronically generated, or verbal in accordance with the Practice Direction on Prescribing.

4. Sample Medication

4.1. A registrant must keep sample medication in a secure location; dispose of sample medication in a safe and environmentally acceptable manner; not offer to sell or barter sample medication for any purpose whatsoever, and not have any form of material gain from distributing the sample medication.

4.2. A registrant must ensure that if a sample drug is provided to the patient it is provided with clear instructions for its use, including any precautions; and it has an unexpired date of use.

[3] Paper prescriptions handed to the patient must be signed in ink by the prescriber. Electronically transmitted prescriptions may be signed electronically.

[4] This can be the hospital, clinic, or institutional phone number. If desired, a prescriber may also include a personal phone number on electronic prescriptions.

5. Manitoba Prescribing Practices Program (M3P Drugs)

5.1. In addition to this Standard of Practice M3P drugs must be prescribed in accordance with the M3P Practice Direction.

6. Dispensing Physician

6.1. In addition to this Standard of Practice, if dispensing drugs, must do so in accordance with the Dispensing Physician Practice Direction.

Part 6 – Practice Direction – Electronic Transmission of Prescriptions

Currently, there are two separate joint College Practice directions entitled the "Facsimile Transmission of Prescriptions and "Electronic Transmission of Prescriptions" respectively. The Prescribing Practices Working Group is currently considering whether to recommend that one Practice Direction will replace the two current joint Practice Directions.

Extensive work has been done and a Joint College Practice Direction which is close to finalization has been circulated to The Colleges of Pharmacists and Registered Nurses, the Manitoba Veterinary Medicine Association and the Manitoba Dental Association. This Practice Direction is included below.

Regarding the transmission of M3P (and non-M3P prescriptions) by other methods (specifically via email), CPhM and CRNM staff members expressed strong interest. However, they indicated this will require further discussion within their organizations before bringing to their respective Councils. The dental and veterinary associations are also considering this.

Recommended Changes

The important change is this document will permit emailing of prescriptions. Major changes are

1) Combining two Practice Directions for Facsimile and Electronic into one.
2) Permitting that prescription be transmitted by email.
3) The addition of a purpose statement to the Practice Direction.
4) A description of potential security features and/or safety measures when transmitting prescriptions electronically.
5) The required content has been changed to reflect changes made in the CPSM Standard of Practice entitled "Prescribing Requirements". This is important for consistency as this document applies to five organizations, whereas the "Prescribing Requirements" Standard of Practice is a CPSM document.
6) Prescribers and pharmacists have a joint responsibility to maintain confidentiality. In the previous document, this responsibility was placed upon the prescriber.
7) Veterinary prescriptions are exempted from the confidentiality provisions (I.e.., privacy rights) and such prescriptions are not requirement to include a treatment goal and/or diagnosis and/or clinical indication(s) as pharmacists do not typically modify and/or adapt veterinary prescription. Veterinarians are the sole profession that is educated in animal health.

Standard of Practice

Electronic Transmission of Prescriptions

DRAFT

Initial Approval: **Effective Date:**

This joint Practice Direction is the result of Interprofessional Collaboration between:

- College of Pharmacists of Manitoba (CPhM),
- College of Physicians and Surgeons of Manitoba (CPSM),
- College of Registered Nurses of Manitoba (CRNM),
- The Manitoba Dental Association (MDA), and
- The Manitoba Veterinary Medical Association (MVMA).

Purpose

To better serve all patient populations (urban, rural, and remote) and to leverage the benefits of modern technology, the electronic transmission of prescriptions is necessary to ensure timely access to care. The purpose of the *Practice Direction: Transmission of Prescriptions* is to outline the minimum practice expectations for health professionals whose scope of practice includes prescribing. The practice direction clarifies what the public can expect in terms of safeguards around electronic transmission of prescriptions.

1. Definition and Application

"Electronic transmission of prescription" is the communication of an original prescription or refill authorization by electronic means, to include computer-to-computer, computer-to-facsimile machine, facsimile machine to facsimile machine, facsimile machine to computer or e-mail transmission which contains the same information it contained when the authorized prescriber transmitted it, but does not include verbally transmitted prescriptions.

This joint Practice Direction applies to all medications prescribed for outpatients and persons receiving care in an ambulatory community practice. The Manitoba Prescribing Practices Program (M3P) Practice Direction will supersede this practice direction when the drug being prescribed is on the M3P drug schedule.

2. Electronic Transmission of Prescriptions

2.1. Principles

In consideration of patient safety and to minimize the risks associated with drug diversion, prescribers and pharmacists must adhere to the following principles:

2.1.1.a. the process must maintain confidentiality. It must do so by either facsimile, a closed e-prescribing system, or by means of another form of encryption or password protected email[5]. Prescribers and pharmacists are jointly responsible for maintaining the confidential nature of electronic transmission.

2.1.1.b. the accuracy and authenticity of the prescription must be able to be validated.[6]

2.1.1.c. the process must incorporate mechanisms[7] to decrease prescription forgery risk, and minimize the prescription being transmitted to more than one pharmacy; and

2.1.1.d. the patient's choice of pharmacy must be protected, taking into consideration the treatment plan and drug availability.

2.2 Shared Responsibility

2.2.1 To facilitate congruence with the above principles, prescribers and pharmacists have the following responsibilities

2.2.1.a. the prescriber must ensure the prescription is transmitted directly to the pharmacist in a clear, unambiguous manner and the mode of transmission is secure and maintains confidentiality; and

2.2.1.b. the pharmacist must only accept a prescription once satisfied that it came directly from someone who has the authority to prescribe, and the prescription is appropriate for the patient. A pharmacist is also responsible for verifying a prescriber's written and/or electronic signature if it is unknown to the pharmacist.

2.2.1.c. both prescribers and pharmacists must ensure that prescribing is done in accordance with each prescriber's scope of practice (as outlined by their regulatory body).

2.3. Safeguards

The following additional safeguards apply to electronic prescriptions:

[5] Veterinary prescriptions are exempt from section 2.1.1.a.

[6] Mechanisms for prescription validation must include at least one of the following, which are not limited to: a unique verifiable prescriber signature, a unique prescriber encryption code or key, a prescriber phone number/email address which can receive and respond to urgent communication,

[7] This must include (at minimum): The use of a private (dedicated) professional email address. For email and non-facsimile electronic transmission, documents must be encrypted (password-protected) or an alternate method of encryption used (i.e., unique prescriber login, biometric protected, use of individual key fobs.)

2.3.1 All prescriptions transmitted electronically (except veterinary prescriptions) must be entered into the Drug Program Information Network (DPIN) to enhance patient care and safety, and to restrict opportunities for potential prescription fraud.[8]

2.3.2 After transmission, the prescriber must ensure that the original prescription is invalidated to ensure it is not transmitted elsewhere at another time. A prescription record must be retained in accordance with the prescriber's regulatory body.

2.3.3 Pharmacists must ensure the electronic and facsimile equipment at the pharmacy must be under the control of the pharmacist so the transmission is received and only handled by staff in the dispensary in a manner which protects the patient's privacy and confidentiality.[9] Prescriptions, including any relevant prescription information received by electronic transmission must be appropriately filed by the pharmacist in accordance with CPhM's record keeping requirements.

3.1. Content of Electronic Prescriptions

The prescription must be legible and must include the following information:

- The prescriber's printed name, signature, practice address, and CPSM/CPhM/CRNM/MDA/MVMA Registration number.
- The patient's name and either date of birth or Personal Health Information Number (PHIN);
- The name of the drug;
- The drug strength, quantity, and formulation (tablet, liquid, patch);
- The directions for use;
- The treatment goal and/or diagnosis and/or clinical indication[10];
- The full date the prescription was issued (day, month, and year);
- Refill instructions, including dispensing intervals, if applicable;
- The time and date of prescription transmission;
- The name and address of the one pharmacy intended to receive the prescription;
- Method to contact the prescriber – telephone number, email address, or facsimile number.
- Prescriptions from Associate Members of the CPSM including Clinical Assistants, Physician Assistants or graduate medical students on the Educational Register must include the name and telephone number of both the associate Registrant and the supervising physician must be included on every prescription.

[8] Should a patient refuse a drug that falls under the Controlled Drugs and Substance Act (CDSA) be entered into DPIN under their PHIN (or if they do not have a Manitoba PHIN), a pharmacist must directly confirm prescription authenticity with the prescriber. Such drugs would include opioids, controlled medications, benzodiazepines, and targeted substances.

[9] For greater clarity, dedicated pharmacy electronic and/or facsimile equipment must not be accessed by individuals who are not authorized pharmacy staff.

[10] Veterinary prescriptions are exempt from providing a treatment goal and/or diagnosis and/or clinical indication.

- Signed certification that:
  A) the prescription represents the original of the prescription drug order,
  B) the addressee is the only intended recipient and there are no others, and
  C) the original prescription will be invalidated, securely filed, and not transmitted elsewhere at another time.

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 review of prescribing rules is overdue. Technology has changed, society has different expectations regarding service, there is much experience with the M3P system of prescribing controlled drugs and substances. Finally, the pandemic provided an experiment in alternative ways to prescribe that were implemented immediately and have been rather successful.

The most important aspects in any consideration regarding prescribing are access to drugs and patient safety. This has informed every single decision made by the Working Group. Several members of the Working Group also practice in remote Northern communities and with disadvantaged patients and have provided a wealth of experience in how to best provide access to drugs and ensure patient safety in revising the rules for prescribing. It has also been important to have a participant who practices addictions medicine who is able to draw upon their experience with many of these patients with very challenging prescribing needs.

Ultimately, all decisions have been reviewed through access to care/prescribed medicine, patient safety, and risk to both the patient and the public. This constitutes the public interest.

A regulatory impact assessment will be prepared for Council when the full materials are ready for the review prior to the recommended implementation.

Possible Questions for Council

- If electronic e-mail prescriptions of M3P drugs are permitted, then how will an electronic M3P prescription be different than a regular prescription?
- Should the clinical indication/diagnosis/treatment plan be included on every prescription?

- For public representatives: Faxing? Really? Why is the medical profession so reliant upon faxing in 2022?
- What type of password protection or encrypted software is needed for transmitting prescriptions by email?
- When will all the relevant materials be presented to Council for its approval?
- Will there be a plan for change management in prescribing across all applicable regulators in Manitoba when the time comes? Why wait until all the changes are made instead of implementing them a little at a time?
- When will all of the issues be addressed and this strategic organizational priority be finished?
- What types of drugs can pharmacists bridge now and how is this different than renewing?

COUNCIL MEETING - DECEMBER 1, 2022

BRIEFING NOTE

TITLE: **Performance Metrics**

BACKGROUND

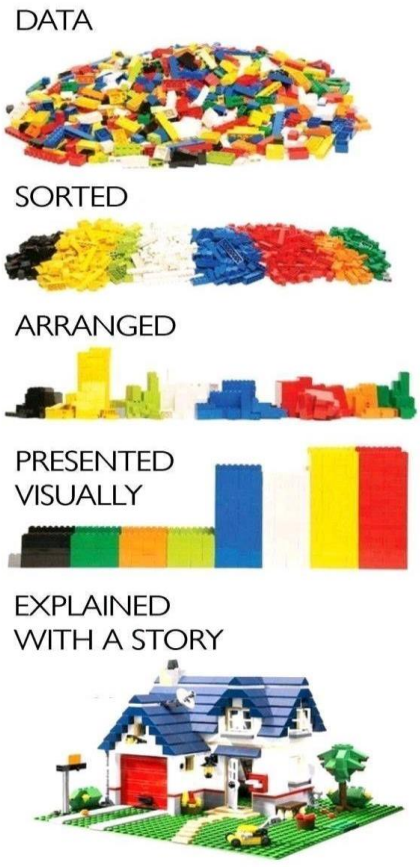
Creating performance metrics is a strategic organizational priority directed by Council in June 2022.

Update on Performance Metrics development

CPSM is in the process of reviewing what data is currently being captured and reported with an eye on which components can be defined as workload, legislative/contractual requirements and measures that show progress in delivering on strategic objectives such as x number of standards were successfully reviewed and updated. While the eventual goal is to define and provide "Key Performance Indicators", CPSM is working on defining performance metrics by area for eventual reporting.

In reviewing potential performance metrics, there will be a requirement for select performance indicators to be accompanied with additional information to provide proper context or "story". Some quick examples are;

1. In measuring the length of time for a complaint to be resolved, any potential benchmark must include the fact that the complainant and the registrant both have 30 days to respond.
2. If a complainant wishes to appeal a decision, the complainant has 30 days to inform CPSM of their decision to appeal and at that point has an additional 30 days to provide the reasons for the appeal
3. In measuring the time to register and applicant, there are multiple scenarios that are out of CPSM's control in issuing the "final" registration. There are cases where an applicant is "registration ready" but is not fully registered for a number of months due to delays by an outside party.



CPSM Current Performance Metrics

CPSM provides the following performance metrics in its annual report.

F. LENGTH OF TIME REQUIRED TO RESOLVE COMPLAINTS *For cases closed between May 1, 2021, and April 30, 2022:*	
Within 0 – 60 days	**7**
Within 61 – 90 days	**17**
Within 91 – 120 days	**28**
Within 121 – 150	**13**
Within 151 – 180 days	**12**
Greater than 180 days	**11**
Total	**88**

Our goal is to resolve cases by 120 days or less. That goal was achieved in 52 of the 88 closed cases this year.

C. DISPOSITION OF THE 78 CASES CLOSED BY INVESTIGATION COMMITTEE:	
1. Closed – No Further Action:	
• with Criticism / Advice	27
• no further action and / or concur with Complaints Committee	27
2. Undertakings	
• Remedial Education	6
• Professional Boundaries Program	2
• Practice Restrictions	1
3. Censure	4
4. Referred to Inquiry *(4 physicians)*	7
5. Withdrawn	4

Note: Complainants can appeal the decision of the Investigation Committee to the Appeal Committee. Appeals do not involve the Complaints and Investigation Department and are a function of the Executive Committee.

D. RESPONSE TIME OF INVESTIGATION COMMITTEE:

The following is the length of time taken to conclude the 78 cases closed by the Investigation Committee.

0 – 3 months:	7
4 – 6 months:	28
7 – 9 months:	26
10 – 12 months:	11
Greater than 1 year:	6

35 / 78 (45%) of cases were finalized within 6 months.

Last year, 20% of cases were finalized within 6 months.

E. DURATION* OF THE 132 OPEN CASES REMAINING AT THE END OF THIS FISCAL YEAR:

0 – 3 months:	32
4 – 6 months:	27
7 – 9 months:	11
10 – 12 months:	33
Greater than 1 year:	29

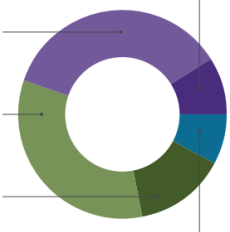
59 / 132 (45%) of cases have been open between 0-6 months.

**Duration of open cases does not always mean a delay in addressing the relevant issues. There are various reasons why investigations may be open for significant periods of time. This can include investigation of multiple or complex issues. It may also include circumstances where physicians are participating in remedial activities or awaiting re-audits after remediation or a period of supervision and monitoring.*

F. LENGTH OF TIME REQUIRED TO RESOLVE INVESTIGATIONS FOR CASES CLOSED:

BETWEEN MAY 1, 2021 AND APRIL 30, 2022

0 - 91 DAYS:	7	8.98%
92 - 182 DAYS:	28	35.90%
183 - 273 DAYS:	26	33.33%
274 - 365 DAYS:	11	14.10%
GREATER THAN 365 DAYS:	6	7.69%
TOTAL	78	100%



BC Examples of Performance Metrics

CPSM has also been investigating what other medical regulatory authorities are using to report to their Councils. Recent CPSM was able to meet with the Registrar from CPSBC. The Registrar provided CPSM with two PowerPoint presentations that were previously presented to the CPSBC Council. CPSM is reviewing the performance indicators and the reporting template. An example of the template and measures are shown below.

Complaints and practice investigations

Goal:

Regulatory compliance/adequacy of investigations

Objectives:

1. Inquiry matters are concluded within statutory timelines
2. Inquiry matters appealed to the HPRB are upheld
3. Effective and efficient practice investigations

College of Physicians and Surgeons of British Columbia 6

Key performance indicator

KPI	Related goal/objective	Target in 2021/22	Baseline (last year)	Actual as of August 31, 2021	Actual as of February 28, 2022	● ● ●
% meeting timelines	Compliance with statutory timelines	30%*	47%	47%	43%	●
# returned	Inquiry matters are upheld	<10	3	3	4	●
% of project completed	Timely completion of practice investigations	100%	0%	80%	100%	●
* These timelines are under review by Ministry of Health						

College of Physicians and Surgeons of British Columbia 7

CPSM has begun to process to use the template above for all areas of the College as well as the strategic priorities approved. Below is some of the **preliminary** work from Complaints and Investigations.

Complaints and Investigations

Goal:

Protect the Public and Improve the Quality of Care

Objectives:

1. Patient safety is an identified priority and embedded in all of our processes
2. Improve the Quality of Care provided
    1. Identify and address deficiencies in care and conduct through education
3. Investigation matters are concluded within established timelines
4. Ensure our processes are helpful, respectful and culturally appropriate
5. Effective and efficient practice investigations

Key performance indicator – Complaints and Investigation

KPI	Related goal/objective	Target in 2022/23	Baseline (last year)	Actual as of XX date	Actual as of Year-End	● ● ●
High Risk Cases are reviewed within 24 hours	Patient safety	24 hours	Data points to be developed with IT			
Complaints review target timeline	Investigation matters are concluded within timelines	All complaints reviewed within 4 days Red flag cases with 24 hours				
Investigations are Completed within 120 days	Investigation matters are concluded within timelines	50% of cases are completed within 120 days	45% of cases completed within 120 days			
Complainants are contacted and connected through the process	Ensure our processes are helpful, respectful and culturally appropriate	Benchmark to be developed				

Other Performance Metrics

In addition to the information from CPSBC, departments are reaching out to their key contacts. A comprehensive list from the Federation Law Societies of Canada performance metrics was obtained. The National Discipline Standards, which is attached for your review, has several potential performance metrics that will be applicable in particular to the Complaints and Investigations Department. As side-by-side comparison with CPSM's Complaint and Investigation Department is included at the end of this document

Council Meeting

A discussion on the possible performance metrics to be utilized by CPSM will occur at the Council Meeting. The Registration and Quality Department will be providing updates regarding their performance metrics development at the next Council meeting

National Discipline Standards & CPSM Complaints and Investigations		
Side by side comparison		
	Federation of Law Societies of Canada	**The College of Physicians & Surgeons of Manitoba**
Timeliness		
Telephone Inquiries	75% are acknowledged within 1 business day and 100% within 2 business days	Telephone Inquiries are acknowledged, response timelines are 100% within 2 days
Written Complaints	95% within 3 business days	Portal complaints receive and automatic response at the time of submission
Early Resolution	there is a system in place for early resolution of appropriate complaints	there is a system in place for early resolution of appropriate complaints
Timelines to resolve of refer a complaint	a) 80% complaints are resolved within 12 months	approx 85 % of all cases resolved or referred within 12 months (2021-22 data)
	b) 80% of appeals resolved within 90 days	review required to identify the metric
	c) 80% of those matters resolved for disciplinary response within a further 12 month	due to the small numbers - are not currently tracked
Contact w Complainant	For 90% of open complaints there is contact with the complainant at lease once every 90 days during the investigation stage.	this is occurring however timelines not currently being tracked
Contact w Registrant	For 90% of open complaints there is contact with the registrant at least once every 90 days during the investigation stage	Contact with registrant is occurring however timelines not being tracked
Interim Measures	There is authority and a process for the Society/College to obtain an interlocutory or interim suspension, restrictions or conditions on a registrant	Yes

Hearings	75% of citations or notices of hearings are issued and served upon the registrant notary within 60 days of authorization	Yes
	75% of all hearing commence within 9 months of authorization	RHPA dictates the timelines 120 days – CPSM does not track
	Reasons for 90% of all decisions are rendered within 90 days from the last date the panel receives submissions	Yes
Public Participation	There is public participation at every stage of discipline	Yes
	There is a complaints review process in which there is public participation for complaints that are disposed of without going to a charging committee	In CPSM's resolution by communication process there is no public participation or representation from the public
Transparency	Hearings are open to the public	Yes
	Reasons are provided for any decision to close hearings	Yes
	Notices of charge are published promptly after a date for the hearing has been set	Yes
	Notices of hearing dates are published at least 60 days prior	Yes
	Information about a registrant either upon request or at its own initiative , with any other Society/College, or can require a registrant to disclose such information to which they are a member.	Yes - through the Certificate of Professional Conduct (COPC)
	There is an ability to report to Police about criminal activity in a manner that protects solicitor/client privilege.	Statutory ability to report where appropriate

Accessibility	A complainant help form is available to complainants	Yes via the Portal and assistance through staff
	There is a directory available with status information on each lawyer including easily accessible information on discipline history	Yes
Qualifications of Adjudicators, Staff and Volunteers	Ongoing mandatory training and refresher training for all adjudicators	In-house training for committee members at the outset of their term
	Mandatory orientation for volunteers involved	NA
	Ongoing training available for all staff involved in complaint	Informal
Reporting on Standards	Each society/college will report annually to it's governing body on the status of the standards	Currently reported through the CPSM Annual Report

Federation of Law Societies of Canada

Fédération des ordres professionnels de juristes du Canada

NATIONAL DISCIPLINE STANDARDS

(Approved June 7, 2021)

Timeliness

1. **Telephone inquiries:**
   75% of telephone inquiries are acknowledged within one business day and 100% within two business days.

2. **Written complaints:**
   95% of written complaints are acknowledged in writing within three business days.

3. **Early resolution:**
   There is a system in place for early resolution of appropriate complaints.

4. **Timeline to resolve or refer complaint:**
   (a) 80% of all complaints are resolved or referred for a disciplinary or remedial response within 12 months.

   90% of all complaints are resolved or referred for a disciplinary or remedial response within 18 months.

   (b) Where a complaint is resolved and the complainant initiates an internal review or internal appeal process:

   80% of all internal reviews or internal appeals are decided within 90 days.

   90% of all internal reviews or internal appeals are decided within 120 days.

   (c) Where a complaint has been referred back to the investigation stage from an internal review or internal appeal process:

   80% of those matters are resolved or referred for a disciplinary or remedial response within a further 12 months.

   90% of those matters are resolved or referred for a disciplinary or remedial response within a further 18 months.

5. **Contact with complainant:**
   For 90% of open complaints there is contact with the complainant at least once every 90 days during the investigation stage.

6. **Contact with lawyer or Québec notary:**
   For 90% of open complaints there is contact with the lawyer or Québec notary at least once every 90 days during the investigation stage.

7. **Interim measures:**
   There is authority and a process for the law society to obtain an interlocutory or interim suspension, restrictions or conditions on a member's practice of law, as the public interest may require.

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NATIONAL DISCIPLINE STANDARDS

(Approved June 7, 2021)

Hearings

8. 75% of citations or notices of hearings are issued and served upon the lawyer or Québec notary within 60 days of authorization.

   95% of citations or notices of hearings are issued and served upon the lawyer or Québec notary within 90 days of authorization.

9. 75% of all hearings commence within 9 months of authorization.
   90% of all hearings commence within 12 months of authorization.

10. Reasons for 90% of all decisions are rendered within 90 days from the last date the panel receives submissions.

Public Participation

11. There is public participation at every stage of discipline, e.g. on all hearing panels of three or more, at least one public representative; on the charging committee, at least one public representative.

12. There is a complaints review process in which there is public participation for complaints that are disposed of without going to a charging committee.

Transparency

13. Hearings are open to the public.

14. Reasons are provided for any decision to close hearings.

15. Notices of charge or citation are published promptly after a date for the hearing has been set.

16. Notices of hearing dates are published at least 60 days prior to the hearing, or such shorter time as the pre-hearing process allows.

17. A law society can share information about a lawyer or Québec notary, either upon request or at its own initiative, with any other law society, or can require a lawyer or Québec notary to disclose such information to all law societies to which they are a member. All information must be shared in a manner that protects solicitor-client privilege.

18. There is an ability to report to police about criminal activity in a manner that protects solicitor/client privilege.

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NATIONAL DISCIPLINE STANDARDS

(Approved June 7, 2021)

Accessibility

19. A complaint help form is available to complainants.

20. There is a directory available with status information on each lawyer or Québec notary, including easily accessible information on discipline history.

Qualification of Adjudicators, Staff and Volunteers

21. There is ongoing mandatory training for all adjudicators with refresher training no less often than once a year, and the curriculum for mandatory training will comply with the national curriculum.

22. There is mandatory orientation for all volunteers involved in conducting investigations or in the charging process to ensure that they are equipped with the knowledge and skills to do the job.

23. There is ongoing training available for all staff and volunteers (where applicable) involved in law society complaint and discipline processes to ensure they are equipped with the relevant skills, knowledge, awareness and understanding of issues that can materially impact a lawyer or Quebec notary's conduct and/or competency.

Reporting on Standards

24. Each law society will report annually to its governing body on the status of the standards.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING - DECEMBER 14, 2022

NOTICE OF MOTION

Title: Practice Direction – Prescribing Methadone or Buprenorphine/Naloxone

This regulatory impact assessment forms the briefing note for this item.

CPSM Regulatory Impact Assessment – November 7, 2022

Background/Issue: The prescribing of methadone and buprenorphine/naloxone (Suboxone) became fully regulated at the provincial level in 2018, after the federal exemption to prescribe methadone was removed. In November 2018, the Practice Direction for Prescribing Methadone or Buprenorphine/naloxone was initially approved. Concurrently, CPSM was awarded a Health Canada Substance Use and Addictions Program grant to support the training, mentoring, and auditing of opioid agonist therapy prescribers. Since 2018, through the grant initiatives, the number of Opioid Agonist Therapy prescribers has grown exponentially from 9 physicians in 2015 to over 170 prescribers in 2022, including physicians and nurse practitioners.

In accordance with the Practice Direction, the Prescribing Practices Program (PPP) ensures the application and training requirements are met by registrants prior to the Registrar granting prescribing approvals for methadone and/or Suboxone. The latter is considered first-line treatment for Opioid Use Disorder and carriers a superior safety profile to methadone. Appropriately, the training requirements for Suboxone-only prescribing for Opioid Use Disorder are less rigorous than those required for methadone approval.

In Manitoba, with the increasing use of Suboxone and growing community of prescribers, the effectiveness and safety of Suboxone has been well demonstrated over the last five years. **However**, **ample time is still being invested by CPSM staff to ensure physicians meet the training requirements to prescribe this life-saving medication**. On average per applicant, a minimum of 6-7 hours of staff time is needed from application to approval (involving administrator, coordinator, medical consultant, and Registrar time). **This is disproportionate to our current assessment of the risk that this medication poses to the public**. In addition, a robust support system is now in place to assist prescribers in using this treatment option safely.

Proposed Solution: Revise the Practice Direction training requirements for Suboxone prescribing so that resources currently allocated to this work can be redirected to other prescribing quality-care initiatives. Revision would see *retention of the vetting component* of the prescribing approval to ensure applicants are appropriate to work with a vulnerable patient population. Further education/training would be *strongly recommended* without requiring that proof of same

be submitted to CPSM. This will shift the onus for training and competency to the registrant, as we do for most other clinical competencies. Subsequently, less CPSM staff time will be needed to educate, coach, and ensure physicians have met all requirements prior to approval.

Requiring prescribing approval but lightening the regulation of Suboxone training is the right-touch regulation that supports patient safety, while potentially increasing access to care.

Accountability: PPP aims to meet the *contemporary* regulatory needs of prescribers, ensuring quality in the practice of medicine and patient safety. While some regulation of methadone and Suboxone is still required, the Opioid Agonist Therapy practice community is now well established and rather self-sustaining. As the grant ends in 2023, the regulatory focus of PPP can shift to other priorities. **Revising the Practice Direction training requirements for Suboxone will decrease the time required to process approvals**. **PPP will re-direct that time to new, more pressing, and higher-impact regulatory projects**.

Timeline: Draft Regulatory Impact Assessment Tool and revise Practice Direction by October 31, 2022, for the following:

Nov 9 – Dr Ziomek and Dr Mihalchuk to meet to discuss Regulatory Impact Assessment Tool submission.

Nov 23 – Regulatory Impact Assessment Tool to be presented at Executive for approval to move forward.

Dec 14 – Regulatory Impact Assessment Tool to be presented at Council for final approval.

Fixed Timeframe Not Applicable ☒

On-going: Revised Practice Direction can be implemented in 2023 Not Applicable ☐

Alignment of Organizational Priorities: Re-allocating PPP resources to new and more-pressing prescribing initiatives strongly aligns with the organizational priority to rebrand CPSM's identity as Quality Care, and inherently improves patient safety. As the practice of medicine evolves, so must regulation. PPP is the program that can dynamically respond to changes in prescribing trends that require regulatory focus. Council has recognized that PPP provides high-impact and focused education to registrants through prescribing advice, mentoring, and many collaborative initiatives. Supporting registrants in this way continues to build capacity, proficiency, and intervenes before concerns may be escalated to Complaints and Investigations.

Patient Safety: With the demonstrated safety profile of Suboxone and the established Opioid Agonist Therapy community for support and mentorship, the regulation of its prescribing should be less rigorous. Physicians interested in providing Suboxone must meet their professional expectation to ensure they possess adequate knowledge, skill, and judgment to prescribe safely. The Opioid Agonist Therapy community now offers adequate supports for new prescribers: PPP capacity for mentoring by phone and email, a robust CPSM list of approved Opioid Agonist Therapy mentors from every health region, the HSC Addiction Medicine Consult Service, the Rapid Access

to Consultative Expertise in psychiatry line, Rapid Access to Addictions Medicine on-call, and over 170 approved prescribers.

Risk Analysis: Suboxone, compared to the second-line treatment option methadone, is a much safer alternative due to its unique partial-agonist pharmacology. Since Suboxone became available in Manitoba, it has not been identified as a primary cause, or major contributor, to any overdose deaths. CPSM's Manitoba Opioid Agonist Therapy Recommended Practice Manual provides additional guidance to improve quality and safety in Opioid Agonist Therapy practice.

Public Risk: Low due to the Suboxone's safety profile and current robust practice supports.

Reputational Risk: CPSM is frequently criticized for over-regulation by registrants and other system and government leaders who see prescribing approval as a barrier to timely prescribing. Compared to a Canadian scan of Opioid Agonist Therapy regulation, CPSM is among the more rigorous of regulators by requiring approvals, mandating training, and requesting proof of same. While some provinces (BC, AB, ON, NL) are more liberal in Opioid Agonist Therapy regulation (no longer require approval or proof of training), these provinces still recommend and expect registrants to pursue training for competency. The onus to ensure adequate the knowledge, skill, and judgment to prescribe lies with their registrants.

Regulatory Risk: Inappropriate or unsafe prescribing of Suboxone could occur if registrants do not pursue adequate training for competency. The patient risk if this occurs is considered low.

Operational Risk: Time committed to regulating prescribing approvals detracts from operationalizing newer quality care initiatives identified in current medical practice and by Council priorities.

Regulatory Impact on Members: The onus to ensure adequate training for competency to prescribe Suboxone will shift to registrants. Overall, this should have a positive impact on registrants, who can be informed of training recommendations at the forefront of application. Subsequently, less time and correspondence will be required of registrants to provide proof of training. Registrants will be reminded to retain documentation of training if required for future regulatory investigation or audit purposes.

Financial Impact: The re-allocation of staff resources would have no net financial impact, but would allow for investment in other priorities. Revising the Practice Direction and review with the Executive and Council will require some up-front demands on staff time.

Human Resources: Per applicant, a minimum 6-7 hours of staff time is needed from application to approval (involving administrator, coordinator, medical consultant, and Registrar time). With some applicants, more time is required. This includes communication with registrants (coaching through steps, criteria, preceptorship/mentorship), drafting and sending letters, communication with references, vetting, record keeping, review of applications, approval, and follow up

communication. The mid-process correspondence (education, coaching, and record keeping) requires primarily clinical consultant (coordinator) time and is typically about meeting the multistep training requirements. **If proof of training was no longer required but strong recommendations summarized for applicants upon approval, the anticipated time investment would be cut in-half for Suboxone applications.**

Financial: As our regulatory work around quality care increases, re-allocating PPP staff time to other prescribing priorities may delay the need for more program staff to meet the growing demands of the organization and registrants.

Infrastructure: Not Applicable ☒
Transition Budget: Not Applicable ☒

Alternatives or Status Quo: The alternative would be to leave the Practice Direction as is. However, to meet CPSM's organizational priorities and growing quality care initiatives, more resources are required.

Evaluation and Outcomes: PPP already tracks the number and nature of inquires related to concerns involving Opioid Agonist Therapy. PPP also monitors problematic and unsafe prescribing practices through the Medical Examiner Death Review Program. Cases of inappropriate prescribing and dispensing of Suboxone would continue to be evaluated by these means. We would anticipate a slight and temporary increase in calls and inquires with this small change to the Practice Direction.

Additional Information: Please see the attached suggested revisions the existing Practice Direction for Prescribing Methadone or Buprenorphine/naloxone.

Recommendation: Revise the Practice Direction training requirements for Suboxone prescribing so that CPSM resources currently allocated to this work can be redirected to other prescribing quality-care initiatives. Retain the prescribing approval requirement but shift the onus for training and ensuring competency to the registrants. Inform applicants upon approval of the strong recommendation to ensure training for competency and emphasize the importance of retaining documented evidence of training for potential future regulatory needs.

Submitted by: Talia Carter & Marina Reinecke, Prescribing Practices Program

Possible Questions for Councillors:

- The overdose deaths in Manitoba are extremely high. Will this improve patient safety either by preventing overdoses or by providing stable treatment for opioid use disorder?
- What is the difference between the current approval process and the proposed vetting process? What exactly is entailed in the vetting?
- Why retain any part of the approval or vetting process if patient safety is paramount?
- Will the approval or vetting process preclude patients from accessing suboxone urgently?
- If an ER doctor has not been vetted for suboxone does that mean that ER doctor can not prescribe suboxone on an emergency basis? What happens if both doctors in the ER have not been vetted?
- Is the vetting a barrier to access?

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the Practice Direction – Prescribing Methadone or Buprenorphine/ Naloxone with the changes as per attached.

PRACTICE DIRECTION

Prescribing Methadone or Buprenorphine/naloxone

Initial Approval: November 22, 2018

Effective Date: January 1, 2019

Reviewed with Changes
March 15, 2018 November 2022

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

The following is an area of practice that requires approval from the Registrar prior to practice.

This Practice Direction is made under the authority of s. 85 of the RHPA with specific reference to s. 5.9 to 5.11 of the CPSM General Regulation.

1. Approval from the Registrar is required to prescribe methadone or buprenorphine/naloxone
   1.1. In accordance with s. 5.9 to 5.11 of the CPSM General Regulation, a member must obtain approval from the Registrar, in an approved form, to prescribe methadone or buprenorphine/naloxone.
   1.2. The following details in the initial application sections constitute the approved form.
   1.3. Registrants must ensure they possess adequate knowledge, skills, and judgment to safely prescribe methadone or buprenorphine/naloxone.

2. The Registrar's approval to prescribe methadone or buprenorphine/naloxone is based on the following criteria:
   2.1. **Prescribing methadone for opioid use disorder**
      2.1.1. Initial application
         2.1.1.a. The Registrar may approve a physician to prescribe methadone for opioid use disorder if the following criteria are met:
            2.1.1.a.i. The applicant must apply in writing for approval to prescribe methadone for opioid use disorder.
            2.1.1.a.ii. The applicant must supply the name of two physician referees who must be contacted directly by CPSM ~~the College~~ for the reference. The references received must be satisfactory to the Registrar.
            2.1.1.a.iii. The applicant must successfully complete a methadone course approved by ~~the Registrar~~CPSM.
            2.1.1.a.iv. Upon completion of the approved course, the applicant must spend at least four half days working directly with a supervising physician approved by ~~the College~~CPSM.

At the end of that period the medical consultant overseeing the Prescribing Practices Program must provide a written opinion to the ~~College~~ Registrar that the applicant has met the criteria to prescribe methadone for opioid use disorder.

2.1.2. Renewal

2.1.2.a. An approval is valid until its expiry date. Irrespective of the date of its issue, all approvals shall expire on June 1, 2021, and, if renewed, every three years thereafter. To receive a renewed approval from the Registrar to prescribe methadone for opioid use disorder, a physician must demonstrate relevant, ongoing prescribing of opioid agonist therapy and compliance with a continuing professional development program relevant to prescribing methadone for opioid use disorder.

2.2. **Prescribing methadone for analgesia**

2.2.1. Initial application

2.2.1.a. The Registrar may approve a physician to prescribe methadone for analgesia if the following criteria are met:

2.2.1.a.i. The applicant must apply in writing for approval to prescribe methadone for analgesia.

2.2.1.a.ii. Supply the name of two referees who must be supervising physicians from the applicant's palliative care or anesthesia training program and who must be contacted directly by ~~the College~~CPSM for the reference. The references received must be satisfactory to the Registrar.

2.2.1.a.iii. The applicant must meet one of the following:

- provide proof, satisfactory to the Registrar, that they ~~he or she~~ held an approval to prescribe methadone from a medical regulatory authority in another Canadian jurisdiction before moving to Manitoba, and that they are ~~he or she is~~ in good standing in that jurisdiction; or
- ~~provide proof, satisfactory to the Registrar, that he or she has met the specific educational requirements approved by CPSM to prescribe methadone in a personal care home setting, and he or she agrees to limit methadone prescribing to that setting.~~
- Provide proof, satisfactory to the Registrar, that the applicant has met the specific educational and training requirements approved by CPSM to prescribe methadone.

2.2.2. Renewal

2.2.2.a. An approval is valid until its expiry date. Irrespective of the date of its issue, all approvals shall expire on June 1, 20222~~21~~, and, if renewed, every three years thereafter. To receive a renewed approval from the Registrar ~~to prescribe methadone for analgesia~~, a physician must demonstrate relevant, ongoing prescribing of methadone for analgesia and ~~physician must demonstrate~~ participation in continuing professional development relevant to prescribing methadone for analgesia.

2.3. **Prescribing methadone for analgesia for palliative care**

2.3.1. Initial application

2.3.1.a. The Registrar may authorize a physician to prescribe methadone for analgesia for palliative care if the following criteria are met:

2.3.1.a.i. The applicant must apply in writing to the Registrar for approval to prescribe methadone for analgesia for palliative care.

2.3.1.a.ii. Supply the name of two referees who must be supervising physicians from the applicant's palliative care or anesthesia training program and who must be contacted directly by ~~the College~~ CPSM for the reference. The references received must be satisfactory to the Registrar.

2.3.1.a.iii. The applicant must meet one of the following:

- provide proof, satisfactory to the Registrar, that he or she held an approval to prescribe methadone for analgesia for palliative cared in another Canadian jurisdiction before moving to Manitoba, and that he or she is in good standing in that jurisdiction; or
- provide proof, satisfactory to the Registrar, that he or she has successfully completed the online methadone for Pain in Palliative Care learning module at http://www.methadone4pain.ca/.

2.3.1.b. The Registrar must impose the following conditions on the recipient of an approval:

2.3.1.b.i. For the first five methadone prescription starts under this approval, the physician is required to contact the on-call WRHA Palliative Care physician through St. Boniface Hospital Paging at (204)-237-2053. This support is available 24/7. The situation and the plan for methadone prescribing is to be reviewed with the palliative care physician, who will provide advice as needed.

2.3.1.b.ii. The palliative care physician is required to chart the discussion and recommendations in the patient's palliative care electronic health record.

2.3.1.b.iii. The physician receiving the advice is required to chart the interaction, advice received, and course of action taken. With ongoing changes in prescription, the physician should call a palliative care physician for advice if any concerns arise.

2.3.1.b.iv. When the mentorship phase is completed (after five prescription starts), the physician may prescribe methadone without the requirement to review with a palliative care physician. Nonetheless, the WRHA palliative care physician group is available on a 24/7 basis for advice regarding palliative methadone prescribing (or for any other clinical palliative care advice).

2.3.2. Renewal

2.3.2.a. An approval is valid until its expiry date. Irrespective of the date of its issue, all approvals shall expire on June 1, 20222~~21,~~ and, if renewed, every three years thereafter. To receive a renewed approval from the Registrar, ~~to prescribe methadone for analgesia for palliative care purposes~~ a physician must demonstrate relevant, ongoing prescribing of methadone for analgesia for palliative care, and ~~a physician must demonstrate~~ participation in continuing professional development relevant to prescribing methadone for analgesia for palliative care.

2.4. Prescribing buprenorphine/naloxone for opioid use disorder

2.4.1. Initial Application

2.4.1.a. The Registrar may approve a physician to prescribe buprenorphine/naloxone for opioid use disorder if the following criteria are met:

2.4.1.a.i. The applicant must apply in writing to the Registrar for approval to prescribe buprenorphine/naloxone for opioid use disorder.

2.4.1.a.ii. ~~The applicant must be registered to prescribe drugs through the Manitoba Prescribing Practices Program (M3P)~~.

2.4.1.a.iii. The applicant must ensure they possess adequate knowledge, skill, and judgment to prescribe buprenorphine/naloxone safely. While proof of the following is not required for approval, it is strongly recommended that the applicant complete the following and retain records of relevant training for future reference:

- It is strongly recommended that the ~~A~~applicant~~s must~~

complete a ~~have completed a recognized course for prescribing~~ buprenorphine/naloxone course approved by ~~the College~~CPSM. The applicant should contact CPSM for a list of approved courses. Courses should not be associated with or sponsored by the pharmaceutical industry. ~~This can be either a course offered by recognized experts in addiction medicine such as that offered by the College or the Canadian Society of Addiction Medicine, or online course not associated with the pharmaceutical industry such as the Centre for Addiction and Mental Health (CAMH)'s Buprenorphine-Naloxone Treatment for Opioid Use Disorder course or the Online Addiction Medicine Diploma offered by the British Columbia Centre on Substance Use~~.

- Upon completion of the course, a period of mentorship is strongly recommended for the first year of prescribing. Mentors must be Manitoba licensed physicians who have experience in prescribing buprenorphine/naloxone and methadone (to discuss the spectrum of OUD care for complex cases). Clinical preceptorship (e.g., one or more half-day clinics) with the mentor can be pursued at the discretion of the mentor and mentee. ~~the applicant must declare to the College which of the two routes outlined below they are pursuing~~:

~~**Route A**. The candidate must spend at least one-half day working directly with a supervising physician approved by the College. At the end of that period the medical consultant overseeing the Prescribing Practices Program must provide a written opinion to the College that the applicant has met the criteria to prescribe buprenorphine/naloxone for opioid use disorder. The applicant must agree to participate in the CPSM prescriber mentorship program for at least the first year of prescribing buprenorphine/naloxone.~~

~~**Route B**. The Registrar must impose the following conditions on the recipient upon authorization of a *conditional* prescribing approval:~~

~~Applicants who have not previously prescribed buprenorphine/naloxone for the treatment of opioid use disorder must have their first five starts mentored by a physician licensed in Manitoba who has experience in prescribing buprenorphine/naloxone.~~

~~Mentorship can be through the Rapid Access to Consultative Expertise (RACE) substance use disorders line (when available). Alternately, the physician may choose to work with another physician, approved by the College, with experience prescribing buprenorphine/naloxone, who agrees in writing to serve as a mentor to the physician. The physician and the mentor must both ensure that each of them creates and maintains appropriate documentation of the discussion and recommendations.~~

~~Once mentorship is completed, appropriate documentation must be sent to the Registrar of the College by the mentor indicating that the applicant physician can prescribe buprenorphine/naloxone without further supervision.~~

2.4.2. Exemption from application criteria

2.4.2.a. Physicians who have extensive experience prescribing buprenorphine/naloxone in other jurisdictions are exempt from conditions imposed in 2.4.1.a.iii~~iv~~, ~~B. below~~ provided that the ~~physician~~ applicant includes appropriate documentation of their experience as part of their application to the Registrar in subsection 2.4.1. above and proof that ~~he or she is~~they are in good standing in that jurisdiction.

2.4.3. Renewal

2.4.3.a. An approval is valid until its expiry date. Irrespective of the date of its issue, all approvals shall expire on June 1, 2021, and, if renewed, every three years thereafter. To receive a renewed approval from the Registrar to prescribe buprenorphine/naloxone for opioid use disorders, a physician must demonstrate relevant, ongoing prescribing of opioid agonist therapy and participation in continuing professional development relevant to prescribing buprenorphine/naloxone for opioid use disorder.

COUNCIL MEETING –DECEMBER 14, 2022

NOTICE OF MOTION FOR APPROVAL

SUBJECT: **CPSM Risk Management Policy**

REFERENCE:

As per the College of Physicians & Surgeons of Manitoba "Governance Policy" under the Finance, Audit and Risk Management Committee (FARMC) terms of reference section in 4.9.2.a the purpose of the FARMC is to assist Council in its oversight of:

4.9.2.a.vi. the effectiveness of the College's risk management practices.

4.9.3.a.iii Periodic review of CPSM's risk assessments on operational, financial, reputational, regulatory, and IT and cyber security risks, and evaluate risk mitigation strategies and activities

BACKGROUND:

CPSM recognizes that there are risks inherent in all facets of our governance, program delivery, and business operations. CPSM is committed to managing risks to the organization, its staff, members, stakeholders and the community.

We take the safety, well-being, and satisfaction of our staff, members and the public very seriously. While we are not adverse to taking organizational risks and pursuing opportunities, we will do so thoughtfully and in an informed manner.

The CEO/Registrar will be responsible for providing information about risks, controls and risk management strategies to Council on a regular basis. Council, through its oversight role, is responsible for ensuring that management has designed and implemented appropriate risk management processes and strategies. CPSM Council is not involved in day-to-day risk management.

Purpose

The purpose of this policy is to provide guidance on how risk management is to be performed at CPSM. In general, CPSM will view risk management as a comprehensive "enterprise-wide" approach to improving organizational performance. This policy serves other purposes as well, including:

- Reinforcing an understanding of risk management as having a broad focus, beyond merely financial and insurance related;
- Performing an educational function for staff, our members and Council;

- Over the longer term, contributing to the enhancement of a "risk management culture" within the organization.

Successful risk management has the following benefits:

- Prevents or limits injury or losses to CPSM, its staff and its members
- Helps ensures that CPSM is compliant with all applicable laws, regulations, and standards;
- Improves the quality and relevance of the work that we do;
- Promotes improved business management and human resource management practices;
- Enhances the CPSM's reputation, and image to our member and in the community;
- Overall, enhances CPSM's ability to achieve its strategic objectives.

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 purpose of risk management is to assist CPSM in achieving its goals (i.e., protecting the public, regulating via right touch regulation). It improves decision-making by ensuring that decisions are based on the most complete and properly analyzed information possible.

To be effective, risk management must be integrated into the entire organization. Council must view risk management as an essential part of CPSM's functioning. The senior leadership has to devote time and resources to risk management activities. Each department needs to see the value of risk management to their activities and its importance to the entire organization. Front line staff must appreciate the significance of their contribution to risk management. In addition, risk management must pervade and be coordinated with the other structures and activities of CPSM including; strategic planning, governance, management, registration, quality, discipline, human resources, and information technology.

Ultimately, risk management must show that the interest of the public is being addressed through this use of this tool.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the Policy – Risk Management as attached, to become effective immediately.

POLICY

Risk Management

Initial Approval: **Effective Date:**

Scope and Authority

The Chief Operating Officer or designate is appointed as Risk Manager and is responsible for the implementation, maintenance, and communication of this policy. This policy applies to all activities undertaken by CPSM.

Policy

CPSM will make the following commitments to its staff, registrants and stakeholders:

- All significant activities undertaken by CPSM will be analyzed from a risk management perspective;
- Steps will be taken to identify, assess, manage, and communicate risk facing CPSM;
- Risk mitigation strategies will be reasonable and will reflect the given standard of care in any circumstance (where standard of care is determined by written/published standards, industry practices established case law precedent, and common sense).

CPSM acknowledges risk management is a broad activity and a shared responsibility. All Directors, Managers and staff have an ongoing responsibility to take appropriate measures within their scope of authority and responsibility to identify, assess, manage, and communicate risks.

Procedures

Managing risk involves four steps:

1. Identify potential risks using an informed, environmental scan approach;
2. Assess the significance of a risk by considering its likelihood and impact (severity);
3. Develop and/or implement measures to mitigate those risks deemed significant by reducing possibility, consequences, or both.
4. Collect & report on the identified risks and mitigation measures through a risk registry tool.

Risks can arise from a number of categories of CPSM's operations. Facility, equipment, people (HR), programs (operations), IT (cyber security risk), financial, reputational, compliance (regulatory), and external are the common areas that give rise to potential risks. CPSM will determine the categories (or buckets) that will be used when identifying risk.

All risks faced by CPSM can be addressed by one or more of the following four general strategies:

- *Retain* the risk – no action is taken because the possibility and consequence of the risk is low. It may also be that the risk is inherent in the activity itself and thus can be accepted in its present form.
- *Reduce* the risk – steps are taken to reduce the possibility of the risk, and/or its potential consequences, through efforts such as improved planning, policies, delivery, supervision, monitoring, or education.
- *Transfer* the risk – accept the level of risk but transfer some or all of it to others through the use of insurance, waiver of liability agreements, or other business contracts.
- *Avoid* the risk – eliminate the risk by avoiding the activity giving rise to the risk – in other words simply decide NOT to do something, or to eliminate an activity or initiative.

The above general strategies translate into a variety of risk control measures, which may include but are not limited to:

- Development of policies, procedure, standards, and rules;
- Effective communication;
- Education, instruction, professional development, and specialized training;
- Ensuring a core set of organizational values have been identified, defined, and communicated throughout;
- Adherence to minimum, mandatory qualifications and/or certifications for key staff and leaders;
- Use of robust and legally sound contracts (code of conduct, employee agreements, contractor agreements, partnership agreements);
- Improving role clarity through use of written position descriptions and committee terms of reference;
- Supervision and monitoring of staff, volunteers, participants, and activities;
- Establishing and communicating procedures to handle concerns, complaints, and disputes;
- Implement schedules for regular review, maintenance, repair, and replacement of equipment;
- Preparing procedures and protocols for emergency response and crisis management;
- Use of warnings, signage, participation agreements, and waiver of liability agreements where warranted;
- Purchasing appropriate insurance coverage for all activities and reviewing regularly.

Reporting and Communication

To ensure risk management remains a high priority within the organization, and to promote an organizational culture that embraces a risk management perspective, CPSM recognizes communication is an essential part of risk management. This policy will be communicated frequently to staff, Council, and Committees.

The state of CPSM risk management will be reported on to Council at least annually in June of each year. Management will report on the status of risk to the Finance, Audit & Risk Management Committee in February of each year and more often as circumstances deem necessary.

Appendix A – Decision Risk Tools

Decision Risk Matrix Assessment (Pascarella, et al., 2021)

Impact/Consequence Levels

		Slight/ Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Likelihood Descriptors		Harm is minor with no treatment required	Harm is minor, minor treatment required	Harm occurs and requires treatment and possible admission	Serious Harm, acute care required	Death or permanent disability
Rare/Remote (1)	May happen only in exceptional circumstances	1 Very Low	2 Very low	3 Low	4 Moderate	5 Moderate
Unlikely (2)	Could happen some time	2 Very Low	4 Low	6 Moderate	8 Moderate	10 Moderate
Possible/ Occasionally (3)	Might occur occasionally	3 Low	6 Moderate	9 Moderate	12 Moderate	15 High
Likely (4)	Will probably occur in most circumstance	4 Low	8 Moderate	12 Moderate	16 High	**20 Very High**
Almost Certain (5)	Expected to occur in most circumstances	5 Moderate	10 Moderate	15 High	**20 Very High**	**25 Very High**

Risk example	Likelihood	Impact	Risk Level	Risk Grading
Patient Injury	Likely (4)	Major (4)	16	High

Likelihood Scoring Table

Likelihood Descriptors	Score	Likelihood Description	Probability	Frequency
Rare/Remote	**1**	This will probably never happen/recur. Will only happen in exceptional circumstance	<5%	Once in more than 10 years or not at all
Unlikely	**2**	Do not expect it to happen but I may do so	>5% - 30%	Once in 5-10 years
Possible/ Occasionally	**3**	Might Happen or recur occasionally	>30 - 70%	Once in 1-5 years
Likely	**4**	Will probably happen/recur, but it is not a persisting issue	>70-95%	Monthly or several times year
Almost Certain	**5**	Will undoubtedly happen/recur on a frequent basis	>95%	Weekly

Control Assessment Questions and Adequacy

Description		Control Assessment Questions								Control Assessment Adequacy			
Risk	Measure in place	Documented Is the control's documentation up to date		Awareness Is the control well communicated		Compliance Is the Control impossible to by-pass		Effectiveness Doe the Control trap its targets consistently		Score Yes	 No	Risk Level	Controls Descriptor
1	A	YES	NO	YES	NO	YES	NO	YES	NO	4	0	E	Excellent
2	B	YES	NO	YES	NO	YES	NO	YES	NO	3	1	A	Adequate
3	C	YES	NO	YES	NO	YES	NO	YES	NO	2	2	Q	?
4	D	YES	NO	YES	NO	YES	NO	YES	NO	1	3	I	Inadequate
5	E	YES	NO	YES	NO	YES	NO	YES	NO	0	4	U	Unknown

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –DECEMBER 14, 2022

FOR INFORMATION

SUBJECT: Strategic Organizational Priorities

BACKGROUND:

In June, Council discussed the Strategic Organizational Priorities of CPSM.

Council directed CPSM staff to undertake a multiyear review of the Standards of Practice, Practice Directions, and Council Policies as a Strategic Organizational Priority. In making its direction, Council indicated not every document will require a comprehensive review with a Working Group, and several will likely be able to be reviewed by staff with minor changes. Of course, any changes to the documents beyond grammar or minor wording requires Council approval.

CPSM has prepared and multiyear review by which in five years all Standards of Practice, Practice Directions, and Council Policies will be reviewed.

There are 31 Standards of Practice, 21 Practice Directions, and 9 Council Policies. CPSM is working its way through them and a number are included in the Prescribing Rules Review. CPSM is also preparing a Social Media Standard of Practice which is almost finalized.

The Strategic Organizational Priorities for 2022/23 are:

• Prescribing Rules Review – Continue
• TRC Anti-Indigenous Racism – Continue
• Standard of Practice – Episodic, House Calls, and Walk-in Primary Care – Continue/Now Finished
• Performance Metrics Creation – New
• Quality of Care as the Identity of CPSM – New
• Standards of Practice, Practice Directions, and Council Policies Multi-Year Review - New

Work is underway on the Prescribing Rules Review, TRC Indigenous-Specific Racism, Performance Metrics, and Quality of Care as the Identity of CPSM. Given the wide-ranging scope of these strategic organizational priorities compared to the more confined priorities of one particular Standard of Practice, these are taking more than the one year to complete. Accordingly, the Executive Committee would like Council to consider foregoing adding any further Strategic Organizational Priorities for 2023/24 and instead have CPSM finish the existing priorities.

As you may recall the format from last year, Council met in February to hold a "Blue Sky" meeting to discuss future Strategic Organizational Priorities in advance of the June meeting in which Council decided upon which Strategic Organizational Priorities were to be chosen for the upcoming year. Therefore, if Council decides this, then there will be no "Blue Sky" meeting in February since the Strategic Organizational Priorities of 2021/22 will carry over to 2022/23.

Dr. Elliott will lead a discussion on this matter.

STRATEGIC ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Prescribing Rules Review	21-Sep-21		Formed					**On Track**	Various Items are on the December Council Agenda for information. This is complex due to the number of Regulatory Bodies involved and the decision to implement almost all changes at one time rather than staggering changes over a period of time.
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners	21-Sep-21		Formed					On Track	The Advisory Circle has met 7 times to date. The group has broken out into smaller subgroups to work on the recommendations.
Episodic Care, House Calls, Walk-Iin Clinics - Standard of Practice	21-Sep-21	21-Jun-21	Formed	22-Mar-21	22-Apr-21	22-Jun-21	1-Nov-22	Achieved	Council approved at September 2022 meeting with effective date of November 1, 2022
Quality of Care as Identity of CPSM	22-Jun-22							On Track	Various initiatives have been undertaken to further this priority but not yet as an organized project.
Performance Metrics Creation	22-Jun-22							On Track	Initial presentation to Council in December 2022
Review of SofP/PD/Bylaws/Policies	22-Jun-22							On Track	This is ongoing over a 5 year period

Last revised: November 28, 2022

COUNCIL MEETING - DECEMBER 14, 2022

NOTICE OF MOTION

SUBJECT: CPSM President-Elect Nomination

BACKGROUND

The nominating and election of the President-Elect are to occur. The Affairs of the College Bylaw requires that the Executive Committee recommends to Council, in its December meeting, at least one nominee for the position of President Elect. That President Elect would take office in June 2023 after Dr. Elliot steps down as President and Dr. Shenouda as the current President-Elect takes the office of President from June 2023 to June 2025. The President-Elect as chosen by Council will serve in that office from June 2023 to June 2025 and as President from June 2025 to June 2027.

The Executive Committee has met and in in a position to recommend to Council one nominee for the position of President Elect. The Executive Committee recommends that Dr. Charles Penner be the President Elect commencing June 2023 for a two-year term. Dr. Elliott will provide a verbal report on this recommendation.

These are the relevant provisions from the Affairs of the College Bylaw:

Appointment of President-Elect

39. The President-Elect must be appointed from Councillors who are regulated registrants according to the following process:
    a. Commencing in 2018, in every second year, the Executive Committee must present a report to Council prior to December, recommending at least one nominee for the office of President-Elect.
    b. In each year when appointment to the office of President-Elect is required, the Executive Committee's report must be included in the agenda material distributed to Councillors in advance of the December Council meeting.
    c. At the December Council meeting, the Chair must ask for nominations from the floor for the office of President-Elect, provided that only Councillors present (either in person or through electronic means) are eligible to nominate from the floor, and that a Councillor may nominate himself or herself as a candidate for President-Elect.
    d. If more than one candidate is nominated for President-Elect, the Registrar must conduct an election by Councillors according to the following process:
        i. No later than the first Wednesday following the December Council meeting, provide to each Councillor:
            1. a form of ballot that lists the names in alphabetical order of all candidates nominated;
            2. voting instructions, including the date and time by which votes must be received by the Registrar; and
            3. such other material as may be required.

ii. Upon receipt of a vote, the Registrar must be satisfied that it is the vote of a Councillor entitled to vote.
iii. The candidate for whom the highest number of votes is cast will be appointed as President-Elect.
iv. In the event of a tie vote, the President shall cast the deciding vote.
v. Any of the candidates for President-Elect may be present at the counting of the ballots.
vi. The Registrar must resolve any dispute or irregularity with respect to any nomination, ballot or election.

Attached is a list of Councillors and their terms.

The Executive Committee is nominating Dr. Charles Penner to be the President-Elect. Dr. Elliott will speak to this nomination. Any other councillor can nominate another Councillor, including themselves, who is a physician. There will be an opportunity to do so at the December meeting.

There are two options for motions depending if any other names are nominated.

MOTION (if only one nomination)

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Dr. Charles Penner be approved as President-Elect of CPSM Council for a two-year term commencing June 2023, immediately following the 2022/23 Annual General Meeting.

OR

MOTION (if two or more nominations)

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

An election be held for the position of President-Elect of CPSM Council for a two-year term commencing June 2023, immediately following the 2022/23 Annual General Meeting between the nominated candidates, Dr. Charles Penner and _____, in accordance with Article 39 of the Affairs of the College Bylaw.

Councillor Term Listing

Council Members	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																							8-Jul-19	19-Jun-23	CPSM Appointed
Albrecht, Ms Dorothy																							23-Jul-18	19-Jun-24	CPSM Appointed
Magnus, Ms Lynette																							16-Jun-18	1-Dec-24	CPSM Appointed
McPherson, Ms Marvelle																							13-Apr-17	2-Apr-26	Government Appointed
Fineblit, Mr. Allan																							30-Mar-17	2-Apr-26	Government Appointed
Penny, Ms Leanne																							17-Dec-19	1-Dec-24	Government Appointed
Councillors																									
Elliott, Dr. Jacobi (P)																							15-Jun-18	15-Jun-25	President
Shenouda, Dr. Nader(PE)																							6-Jan-16	19-Jun-27	President-Elect
Ripstein, Dr. Ira (PP)															X								15-Jun-10	22-Jun-23	Past President completes term
McLean, Dr. Norman																							19-Jun-20	19-Jun-24	Winnipeg
Smith, Dr. Heather																							19-Jun-20	19-Jun-24	Winnipeg
Suss, Dr. Roger																							19-Jun-20	19-Jun-24	Winnipeg
Corbett, Dr. Carrie																							22-Jun-22	15-Jun-26	Winnipeg
Convery, Dr. Kevin																							15-Jun-18	15-Jun-26	East
Monkman, Dr. Lisa																							22-Jun-22	22-Jun-26	North
Penner, Dr. Charles																							19-Jun-20	19-Jun-24	West
Associate Member																									
Barnes, Mr. Christopher, PA																							9-Jun-21	15-Jun-23	Elected Annually
University Appointed (Yearly)																									
Nickerson, Dr. Peter																							1-Sep-22	28-Jun-23	Appointed Annually
as of October 21, 2022																									

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 14, 2022
COMMITTEE REPORTS
FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met in person, with a few members joining virtually, October 11 and November 23, 2022. Most of the matters discussed at the meetings appear on this Council agenda.

An Appeal Panel met on October 20, 2022 to hear three Investigation Committee appeals. Another Appeal Panel met on November 18, 2022 to hear two more Investigation Committee appeals.

Respectfully Submitted,
Dr. Jacobi Elliott
President, CPSM and Chair of the Executive Committee

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. **2nd Quarter Financial Statements - 2022-23 Fiscal Year**
   - Management presented the October 31, 2022 CPSM financial statements.
   - CPSM is reporting a favorable variance in comparison to the budget.
   - This positive variance has resulted from timing issues on the operational expense side as well as unanticipated cost recoveries and higher than anticipated revenue from documentation fees and interest on investments
2. **Audit Plan**
   - The Committee received a presentation on the audit plan from Deloitte.
3. **Risk Management**
   - The Committee approved the Risk Management policy to be sent to Council for approval.
4. **Timing issues related to CPSM's Accounting Year**
   - A briefing note was presented to the council for review and discussion on timing issues related to the audit, the approval of the CPSM operational budget and the timing impact of the FARMC, Executive, Council & AGM meetings.
   - CPSM Senior Leadership will review the meeting schedule and provide options to FARMC and Executive.

Respectfully submitted
Dr. Nader Shenouda
Chair, Finance, Audit & Risk Management Committee

PROGRAM REVIEW COMMITTEE REPORT:

There have been no Program Review Committee (PRC) meetings since the last Council Meeting on 29 September 2022. The last PRC meeting was 7 September 2022.

The next scheduled PRC Meeting is 30 November 2022, which is after the deadline for reports to Council.

PRC's November 2022 Meeting report will be included in the March 2023 Council agenda.

Respectfully submitted
Ms Leanne Penny
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

On September 16, 2022 CC reviewed 12 matters. The outcomes of these investigations were as follows:

- 0 Cases resulted in a letter of criticism
- 7 Cases resulted in a letter of advice
- 2 Cases resulted in a decision that no further action was required
- 1 Case resulted in endorsement of an informal resolution
- 1 Case resulted in a referral to the Investigation Committee
- 1 Case resulted in a deferral to the next meeting as complainant wanted more time to provide further info

On October 4, 2022 CC reviewed 15 matters. The outcomes of these investigations were as follows:

- 1 Case resulted in a letter of criticism
- 5 Cases resulted in a letter of advice
- 8 Cases resulted in a decision of no further action
- 1 Case resulted in endorsement of an informal resolution
- 0 Cases resulted in a referral to the Investigation Committee

Respectfully submitted
Dr. Norman McLean
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

Since our last Council meeting, the Investigation Committee has met on two occasions.

On October the 12th we reviewed 12 matters. The outcomes were as follows:

Criticism – 4

No further action – 3
Undertaking – 1
Deferred – 2
Refer to Inquiry - 2

On November the 9th we reviewed 13 matters which resulted in the following outcomes:
Criticism – 5
Advice – 1
No Further Action - 6
Censure - 1

As of today, there are 159 outstanding investigation cases.

Respectfully submitted
Dr. Kevin Convery, Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

Central Standards Committee (CSC) Activities 2022

The CSC met February 4, 2022, April 8, 2022, and June 3, 2022, September 9, 2022, and November 4, 2022

AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2022

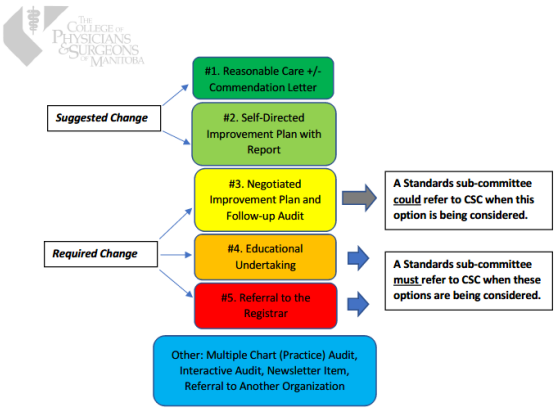
The CSC reviewed:

- 17 age triggered audits
- 5 repeat age triggered audits
- 13 referred audits
- 10 Quality Improvement referred audits

A total of 45 audits have been reviewed by the CSC in 2022.

The following outcomes were determined at CSC.

11	#1 Outcomes
10	#2 Outcomes
14	#3 Outcomes
6	#4 Outcomes
5	#5 Outcomes (2 outcomes from one audit)
	Other – Interactive Audit
46	Total outcomes



Standards Sub-Committee Reporting.

The Central Standards Committee has been receiving quarterly and annual reports from the various Standards Committees within the province. The following table lists currently active and non-active committees as listed in Schedules A, B, C, D of the Central Standards By-Law:

Committee - Active	RHA	Chair	Current Status
Brandon Regional Health Centre ASC	Prairie Mountain	Dr. Nicolaas Butler	New Chair – Approved at November 2022, CSC Meeting
Interlake-Eastern ASC	Interlake-Eastern	Dr. Jonathan Gabor (No longer Chair)	Committee is currently looking for a new Chair.
Northern ASC	Northern	Dr. Shadi Mahmoud	Up to date.
Portage ASC	Southern	Dr. Jim Ross	Up to date.
Prairie Mountain Health ASC	Prairie Mountain	Dr. Shannon Prud'homme	Up to date.
Selkirk ASC	Interlake-Eastern	Dr. Ian Alexander	Require Q1, Q2, Q3 reports.
Boundary Trails Health Centre	Southern	Dr. Kevin Convery	Up to date.
C.W. Wiebe Medical Centre	Southern	Dr. Louw Greyling	Up to date.
Brandon Regional Health Centre Psychiatry	Prairie Mountain	Dr. Gilbert Lee	Committee is on hold due to lack of psychiatrists in Brandon.
Eden Mental Health Centre	Southern	Dr. William Miller	Up to date.
CancerCare	Provincial	Dr. Catherine Moltzan	Received Q1 and Q2 report. Require Q3 reports.
Endoscopy	Provincial	Dr. Ross Stimpson	Up to date.
Orthopedic Surgery	Provincial	Dr. Eric Bohm	Received Q1 and Q2 reports. No meetings in Q3. Next meeting Nov. 7.
Winnipeg Regional Health Standards Committee	WRHA	Dr. Elizabeth Salamon	Up to date.

Committee – Not Active	RHA	Chair	Current Status
Southern ASC	Southern	**Proposed Chair – Dr. Shayne Reitmeier**	Trying to establish committee.
Altona Community Memorial Health Centre	Southern	**Unknown**	Chair needed. Dr. Kyle Winning previous Chair - left province June 2021.
Bethesda Hospital (Steinbach)	Southern	**Unknown**	Currently working with Dr. Denis Fortier – Southern Health CMO
Carmen Memorial Hospital	Southern	**Unknown**	Currently working with Dr. Denis Fortier – Southern Health CMO

Gladstone Health Centre	Southern	**Unknown**	Currently working with Dr. Denis Fortier – Southern Health CMO
Morris-Emerson	Southern	**Unknown**	Currently working with Dr. Denis Fortier – Southern Health CMO
St. Claude, Notre-Dame-de-Lourdes, Treherne	Southern	**Unknown**	Chair needed. Dr. Timothy Gosselin previous Chair.
Ste. Anne Hospital	Southern	**Unknown**	Currently working with Dr. Denis Fortier – Southern Health CMO
Vita & District Health Centre	Southern	**Unknown**	Unknown
Selkirk Mental Health Centre	Interlake-Eastern	**Unknown**	Chair unknown.

Respectfully submitted
Dr. Roger Suss, Chair, Central Standards Committee

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – DECEMBER 14, 2022

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

Changes to Medical Assistance in Dying

In 2021, the Government of Canada announced that changes to Canada's MAID law are officially in force. The new law includes changes to eligibility, procedural safeguards, and the framework for the federal government's data collection and reporting regime. Patients with mental illness will be able to access MAID in March 2023. To help remind you about the changing MAID requirements, the following is taken from the Government of Canada website.

Eligibility

Who is eligible for medical assistance in dying?

New changes to the legislation have allowed a broader group of people to be eligible to request and receive MAID. These changes came into effect on March 17, 2021.

In order to be eligible for medical assistance in dying, you must meet all of the following criteria. You must:

- be eligible for health services funded by the federal government, or a province or territory (or during the applicable minimum period of residence or waiting period for eligibility)
- be at least 18 years old and mentally competent. This means being capable of making health care decisions for yourself.
- have a grievous and irremediable medical condition
- make a voluntary request for MAID that is not the result of outside pressure or influence
- give informed consent to receive MAID

Grievous and irremediable medical condition

To be considered as having a grievous and irremediable medical condition, you must meet **all** of the following criteria. You must:

- have a serious illness, disease or disability (excluding a mental illness until March 17, 2023)
- be in an advanced state of decline that **cannot** be reversed
- experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that **cannot** be relieved under conditions that you consider acceptable.

You do **not** need to have a fatal or terminal condition to be eligible for medical assistance in dying.

Canadians whose only medical condition is a mental illness, and who otherwise meet all eligibility criteria, will not be eligible for MAID until March 17, 2023 (see About mental illness and MAID).

About mental illness and MAID

If a mental illness is the **only** medical condition leading you to consider MAID, you are **not** eligible to seek MAID at this time. Under the new changes made to the law, the exclusion will remain in effect until March 17, 2023.

This temporary exclusion provides the Government of Canada and health professional bodies more time to consider how MAID can be provided safely to those whose only medical condition is a mental illness.

To support this work, the government initiated an expert review to provide recommendations on protocols, guidance and safeguards for those with a mental illness seeking MAID.

After March 17, 2023, people with a mental illness as their sole underlying medical condition will have access to MAID if they meet all of the eligibility requirements and the practitioners fulfill the safeguards that are put in place for this group of people.

If you have a mental illness along with other medical conditions, you may be eligible to seek MAID.

Eligibility is always assessed on an individual basis, taking into account all of the relevant circumstances. However, you must meet all the criteria to be eligible for medical assistance in dying.

CPSM and MAID in Manitoba for Mental Health

I have been asked to participate in Grand Rounds – Psychiatry - MAiD in January 2023. CPSM has been involved with the Department of Psychiatry and Shared Health to discuss the implementation of MAID for patients with mental illness. The very contentious issues are similar across Canada and are included in the attached article to the Globe and Mail. I will discuss this at the meeting.

Regulatory Changes in BC

I like to keep Councillors apprised of major governance issues and changes in medical regulation in Canada. Please see this summary of the changes in BC. Make sure you read the first Backgrounder.
https://news.gov.bc.ca/releases/2022HLTH0202-001566

STAFF MATTERS

Dr. Sonja Bruin joined CPSM on October 31, as the new Medical Consultant for Quality Improvement. Dr. Bruin will join Dr. Marilyn Singer and assist with the oversight and administration of the Quality Improvement Program.

Dr. Ian Wilkinson, Director MANQAP has advised CPSM of his retirement. Ian has been the Director of the Manitoba Quality Assurance Program for 10 years and will retire at the end of December. A job search is underway.

Ms Kathy Kalinowsky, CPSM General Counsel, has also advised she plans to retire in March 2023. Kathy has been with CPSM for five years. Interviews are already scheduled for this position.

Ms Lynne Arnason, General Counsel for Complaints & Investigations Department has advised of her plans to retire in mid 2023. The job search will get underway in the new year.

MEETINGS WITH GOVERNMENT OFFICIALS

Deputy Minister Herd – Phone call

MEETINGS ATTENDED - OTHER ORGANIZATIONS

Provincial CMO/Speciality Lead Meeting – October 6, November 3,

PGME Executive Committee –October 11, November 8

National Committee on Continuing Professional Development – October 14, 2022

Manitoba Clinical Leadership Council Meeting – October 20, 2022

Senate Committee on Medical Qualifications – October 25, 2022 and November 30, 2022

Medicine Subcommittee of Joint Council – October 26, 2022 and November 28, 2022

Shared Health Medical Advisory Committee – October 27, 2022

Presentation on Clinical and Physician Assistants Registration in Manitoba to CPSBC Board/ Provincial Government Representatives – October 21, 2022

Federation of Medical Regulatory Authorities of Canada (FMRAC)

- Board Meeting – October 26, 2022
- Board Meeting – November 4, 2022

MEDIA

CPSM received media inquiries on various topics including some seeking for comments on registrant-specific practices (i.e. circumstances of someone leaving a practice, mask-use in clinics) that for privacy reasons we could not comment on.

Coverage this quarter included the cancellation of Dr. Leonard Lockman's registration and Dr. Berhanu Balcha's censure.

Interviews:

- Dr. Ziomek was interviewed by 680 CJOB following the Summit on Rural & Northern Physician Shortages
- Dr. Ziomek was interviewed by The Medical Post regarding the new Standard of Practice - Episodic Visits, House Calls and Walk-In Primary Care.

COMMUNICATIONS

Print ads acknowledging Patient Safety Week and for general CPSM awareness were placed in publications across the province between October 23 and November 2. Publications included the Winnipeg Free Press, 30 rural publications, and Grassroots News. It included a QR code directing users to a landing page on the CPSM website.

Email from the Registrar acknowledging National Day for Truth and Reconciliation Day (Sept 30) and National Physician Assistant Day (Nov 27, sent to PAs only) were sent to registrants.

A new portal for viewing publications including disciplinary actions was launched on the website. Disciplinary actions are better defined and searchable by type and date.

One hearing date was published on the website this quarter.

FINANCE

Financial Results
The financial results as of October 31 is showing a positive variance compared to the budget. The change from the budget is primarily due to timing issues on the operational expense side, unanticipated cost recoveries, higher than anticipated revenue from documentation fees and interest on investments.

Financial System upgrade
CPSM has completed an upgrade of the current finance information system. The current version and server were in need of replacement due to age. The new system will allow for improved functionality and integration with future enhancements of the Portal.

Audit Plan for 2022-23
The finance team received the audit plan from Deloitte. This was shared with the Finance Audit and Risk Management Committee.

INFORMATION TECHNOLOGY

The IT department continues to implement improvements for our Registrants and increase security of our systems.

Portal Enhancement
The Certificate of Professional Conduct (COPC) can now be requested from the Portal and produces an automatic report for review by the key departments. Turn-around times are now tracked electronically to ensure COPC's are approved within 10 working days. Registrants now have 24 hours to review their COPC prior to it being sent to the requested recipient(s). Previously Registrants were not able to review their COPC's.

Fast Track Registration
The IT group is currently finalizing and testing enhancements to the system that will allow for fast track registration to take place. The current estimated time of completion is the week of December 5th. Implementation of the fast track process has been estimated to require over 200 hours of development and testing time.

CyberSecurity
An email phishing campaign was initiated within CPSM to provide awareness and training for staff. The most effective strategy against cyber intrusions is to have educated staff. The phishing campaign and associated education will be an ongoing initiative.

QUALITY DEPARTMENT

Physician Health Program

- Since September 1, 2022, we've had **27 new referrals**, bringing the total for this fiscal year to 58 so far.
- We have implemented a new **Extreme** level to our contact level ranking system, adding to the existing Low, Moderate and High levels:
    - **Low -** Initial communication with PHP Coordinator identifies nothing reportable to CPSM under the Duty to Report SoP. File is closed without official involvement with Assistant Registrar. Assistant Registrar may advise before closing.
    - **Moderate -** Multiple attempts at communication with registrant and/or meeting required with Assistant Registrar to determine impairment. May require consent and caregiver reports required to close file.

  - **High -** Meeting with Assistant Registrar & Director or PHP required to determine next steps. Consent and caregiver reports are required. CPSM legal likely required. Some result in an undertaking for the registrant involving limited requirements (i.e., BBP diagnosis with bi-annual Hepatology requirements or a depression diagnosis with quarterly Psychology requirements).
  - **Extreme -** SUD and/or severe mental health related cases. Meetings with Assistant Registrar & Director of PHP required. Consent and caregiver reports are always required. Legal department involvement is probable. Will always end in an undertaking with multiple requirements and will be monitored for the longevity of the undertaking, normally a 5-year minimum (i.e., diagnosed with SUD and bi-polar disorder with requirements to see Psych, FP, PAR, etc.).
- 17 of the 27 new referrals have been ranked at a low level, 9 are moderate and 1 has been ranked at an extreme level.
- 10 of the 27 new referrals require follow-ups with the remaining new referrals being closed.
- The top two reported conditions out of the new 27 referrals (aside from "other") are:
  - Mental health related - 8 (30%)
  - Burnout/Stress - 3 (11%)
- The remaining referrals consist of acute injuries, a BBP, Chronic injury/surgery, MS, neurodevelopmental and DUI.

MANQAP

- On-site accreditation inspections of diagnostic facilities have resumed. There has been a large number of inspections this year due to a backlog caused by pandemic-related postponements.
- For Non-Hospital Medical Surgical Facilities new processes and forms are now in place for reviewing and reporting Adverse Patient Outcomes and for providing annual report to CPSM. New standards for these facilities have been approved by PRC and are now in operation. On-site accreditation inspection have begun.

Quality Improvement Program

- Program operations continue – normal pace.
- Auditor Training Workshop planned for December 2, 2022. Attendees being accepted based on CPSM needs/gaps – across all audit programs.
- Continued expansion into different specialty areas year by year.
- Central Standards Committee now oversees the QI Program – process going smoothly.
- QI staffing has doubled to 2 full time administrative staff and 2 0.6 EFT medical consultants to enable meeting the timeline as outlined in the RHPA. New staff are being oriented and trained.

Standards Audits and Monitoring

- 75 Standards audits in total to be initiated for 2022:
  - 11 audits carried over from 2021
  - 14 in the 73 years of age category

  - 25 in the 72 years of age category
  - 11 repeat age triggered
  - 14 referred audits
- 61 audits officially initiated throughout the year. 45 audits which includes any CSC decision for 2022. 16 audits in various stages i.e., waiting for auditor replies, waiting for Manitoba Health info, no auditor, new processes etc.
- 14 still need to be sent the initial pre-audit questionnaire – going out beginning of December.
- 60% complete from 75 with the caveat that there are still audits to be initiated before the end of the year.

Prescribing Practices Program

- SUAP Grant:
  - Responded to 32 OAT Mentoring requests (involving 95 contacts by email/phone) from professionals seeking advice/support (Registrants, Pharmacists, Nurses, Allied Health). 27 (84%) required simple intervention, 4 (13%) intermediate intervention, and 1 (3%) complex intervention.
  - Total 107 OAT Mentoring cases thus far in 2022.
  - OAT Recommended Practice Manual.
    - 3 new chapters completed (17 total chapters posted thus far). 5 chapters in active draft stage.
    - 3 revisions already posted to existing chapters.
    - Consolidating new Suboxone Manual writing with revision of previous Methadone Manual into one manual;
      (now called the Manitoba Opioid Agonist Therapy Recommended Practice Manual).
    - Methadone Manual Induction Revision chapter will be posted early December.
  - Completed 3 OAT Quality Improvement Audits. Planning to complete repeat OAT audits for 2 physicians in early winter 2023.
  - Collaborated with UM CPD Medicine Program to transfer Opioid Agonist Therapy (OAT) workshop to their administration (first UM OAT Workshop help in October, outside of CPSM staff time/funding now).
  - Supported SLT with recent media inquiry re: OAT training.
- OAT Program:
  - Issued 13 OAT (Methadone & Suboxone) Prescribing Approvals since September
  - 26 new OAT approvals total in 2022. Currently 148 Registrants are Approved OAT Physicians.
  - 9 new applicants since September; 4 of the 9 in training process with pending approvals.
- Pain & Palliative Care (P&P) Methadone:
  - Issued 2 Methadone (for palliative care analgesia) Prescribing Approvals in 2022.
- General Prescribing Advice:
  - 25 cases reviewed and general or case-specific prescribing advice provided to health care professionals seeking advice/support.

        - 14 (56%) were Registrants queries, 7 (28%) Pharmacist queries, 4 (16%) other sources.
        - 15 (60%) required simple intervention, 9 (36%) intermediate, 1 (4%) complex.
    - Total 89 General Prescribing Advice cases thus far in 2022.
- CME Death Review Program: Completed review of Q3 2021 cases as able (due to COVID-19 related delays in the Medical Examiner's office finalizing reports):
    - Total of 30 cases identified for review and subsequent communication to physicians.
    - Secondary review process (for physicians with ≥3 concerning cases in the previous 36-month period) planned for 10 Registrants in 2022-2023. Two secondary review letters sent in November 2022.
- Ketamine Project:
    - Other Canadian Colleges shared concerns re: ketamine prescribing in their jurisdictions, including IV ketamine. In response, PPP reviewed DPIN data to determine if similar concerns exist in MB. Based on this data analysis, in October, PPP sent 60 Registrants an online survey re: case-specific ketamine prescribing to determine if further regulatory guidance is needed. At present 30 Registrants have responded (50% response rate).
    - PPP assisted MANQAP/Executive with decision to update the Accredited Facilities Bylaw to include the IV administration of ketamine, whether an off-label use or not (the administration of ketamine for off-label purposes is now only permitted in CPSM accredited non-hospital medical or surgical facilities, or in the hospitals). PPP drafted an IV ketamine position statement which is currently under review by senior leadership.
- Participating in Prescribing Rules Working Group (WG) for review of M3P program. Attended 4 meetings (including 2 smaller working groups) and reviewed documents. PPP will assist in rollout of any changes, including changes to the M3P Program:
    - PPP assisted with drafting revised (draft) Practice Directions and Standards of Practice to present at Prescribing Rules WG meetings. Communicated and collaborated with other Colleges to receive and incorporate feedback into joint Practice Directions.
- Contributing 1 article to CPSM eNews (re: forthcoming M3P changes):
    - PPP will contribute additional newsletter articles, based on changes implemented to Practice Directions and Standards of Practice as a result of Prescribing Rules WG meetings.

COMPLAINTS & INVESTIGATIONS DEPARTMENT

It has now been one year since the new practice direction was approved by Council and fully implemented in the department. As a reminder, the Complaints and Investigation Department has 3 ways to address complaints that are received. There are 3 medical consultants (2.4 EFT positions) who review the matters and write reports for the committees.

Straight forward concerns that can be resolved without review by a committee are addressed through the facilitated communication process ("Resolved by Communication"). There are currently 42 open matters being addressed in this process.

The Complaints Committee reviews matters that appear to have the potential for informal resolution. This involves having the physician provide the complainant with explanations and/or an apology where appropriate. Where this is unsuccessful in addressing the concerns, the Committee will make a disposition. Where this appears to have been successful, the Committee will review and endorse the resolution (where appropriate). There are currently 125 open complaints in various stages of the process.

The Investigation Committee considers matters where the issues raised appear to be more serious or complex, involves a death, involves care by a specialist where a peer opinion may be necessary, or otherwise raises concern for public safety. Meetings are held monthly. There are currently 160 open complaints in various stages of the process.

REGISTRATION DEPARTMENT

Certificate of Practice Renewals for the 2022/2023 were due on 31 October 2022. A total of 3,530 renewals were processed. As of today, 54 registrants have not renewed and have until 30 November 2022 to renew with a late fee. As of 1 December 2022, they will be removed from the active register. Four email reminders were sent and staff have made courtesy calls and have either spoken directly to the registrant, left a message, or have spoken to somebody in their office.

The Fair Registration Practices Office has completed a 10-year review of CPSM's registration processes. A draft report has been issued and will be finalized in December 2022.

Two recommendations from the Fair Registration Practices Office are:

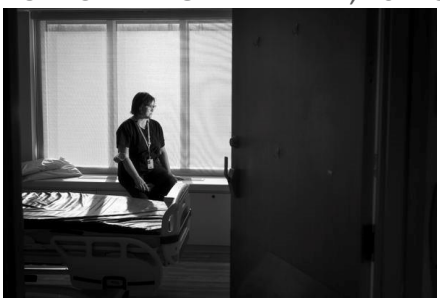
1. Revise information materials for mobility applicants to be clear CPSM is seeking evidence of good character in jurisdictions in which they are no longer registered.
2. Take a lead role in the development of additional capacity and routes for qualified International Medical Graduates to receive licensure opportunities in Manitoba.

Globe & Mail Article

Canada will soon allow medically assisted dying for mental illness. Has there been enough time to get it right?

With doctors divided and federal guidelines still in development, Canadians have questions about who will qualify for MAID next year – and whether it's a good idea to give the most vulnerable an easier way to die

ERIN ANDERSSEN
PUBLISHED NOVEMBER 11, 2022UPDATED YESTERDAY



Psychiatrist Madeline Li worries that Canada is expanding its assisted-dying laws too quickly, without careful safeguards and enough transparent oversight to prevent mistakes. IAN WILLMS/THE GLOBE AND MAIL

The date whispers in Julie Leblanc's mind when she is feeling most hopeless. It tugs at her thoughts when, for days, she forgets to eat, or doesn't shower. She thinks about it more than she knows she should.

On March 17, assisted dying will become legal for Canadians with a mental disorder as their sole condition, and Ms. Leblanc can apply.

She has been struggling with mental illness since she was 8 years old. At 13, she was prescribed her first trial of anti-depressants; now at 31, she has tried too many medications to count, and spent much of her life either in therapy or waiting on a list to receive it. Bounced between doctors, she has been given multiple diagnoses – depression, anxiety, post-traumatic stress disorder, borderline personality disorder.

She wavers between wanting to die and trying to live, especially for her 11-year-old son who is cared for by her parents. She tries to feel hopeful about the earnest new psychiatrist, her third in a year, who patiently listened to her at their first appointment in September. But she is tired of retelling her story. It never seems to help. She feels trapped in despair and anxiety, while carrying the deepest sorrow of all – her illness prevents her from being a good mother to her son.

She has tried taking her own life before. But she worries now about suicide being painful, or ending up in a wheelchair, which happened to someone she knows. She has researched medical assistance in dying online. MAID sounds peaceful, she says. And also too tempting. How can it be, she wonders, that the same system meant to keep her alive might soon help her die?

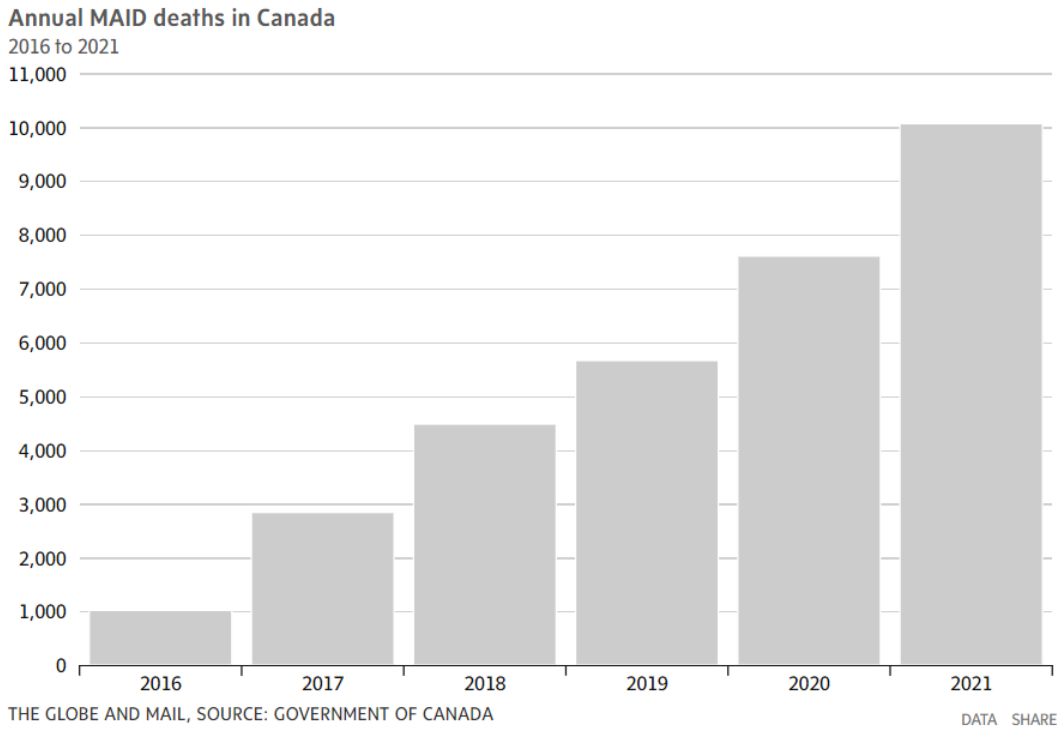
When that option arrives in March, Canada will have one of the most liberal euthanasia laws in the world, joining only a few other countries that allow assisted dying for mental illness.

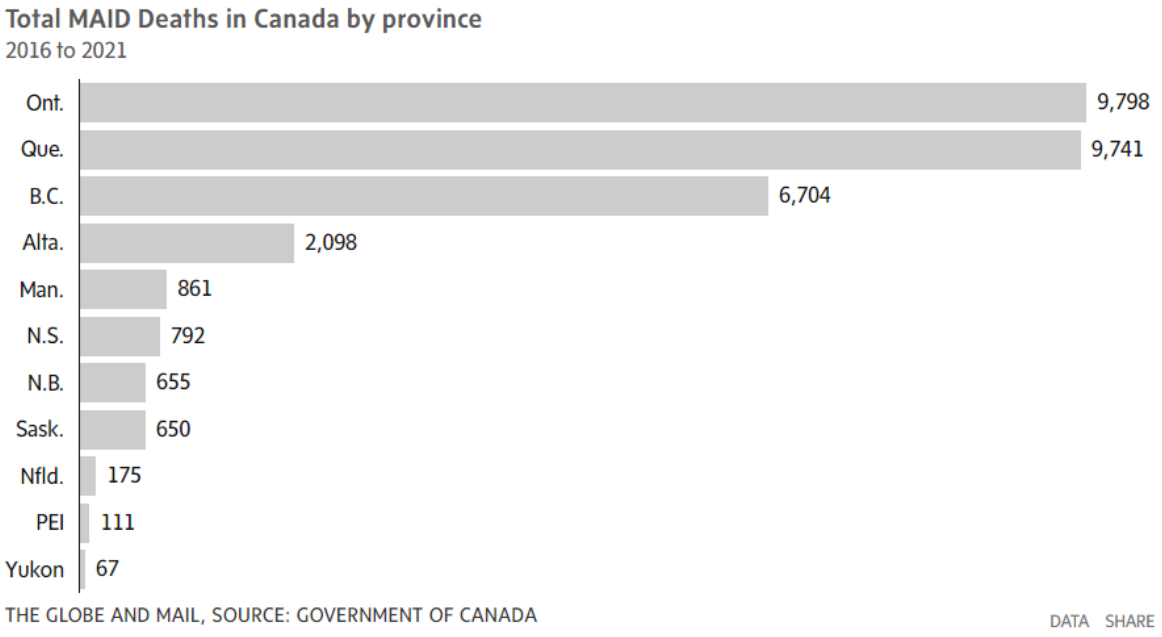
It will be the most controversial expansion of MAID since a Supreme Court ruling led the federal government to legalize euthanasia in 2016. At that time, MAID was only for patients with a foreseeable death, but Parliament – with Bill C-7 – removed that requirement in 2021.

The original version of the bill did not allow assisted death for patients with mental disorders as a sole condition because, the government said at the time, there were outstanding questions about how illnesses such as depression could be safely included, and what the future implications might be. The Senate disagreed, removing that exclusion before the bill passed, but with one caveat: Parliament would study the issue for two years before any of those patients could receive MAID.

With four months to go, there is still no consensus in the mental health community – and, in fact, doctors remain deeply divided. There are no finalized national standards, no transparent review process in place to watch for mistakes, and hospitals are still figuring out how they would implement the change.

Toronto's Centre for Addiction and Mental Health (CAMH), Canada's largest psychiatric teaching hospital, has said that assisted dying shouldn't expand without more study. And the Canadian Mental Heath Association has raised serious concerns about expanding MAID without first increasing mental health care funding. In Quebec, after public consultations, a legislative committee has recommended against the province expanding MAID to mental illness at all.





Meanwhile, In Ottawa, the federal parliamentary committee reviewing the law was supposed to publish recommendations in October. Instead, after months of emotional and polarized testimony from psychiatrists and researchers, the MPs and Senators will now report back next February, just weeks before MAID automatically expands.

Expert dissension, a law without clarity, the arbitrary legislative finish line – all of this would be worrisome, even in normal times. But Bill C-7 passed before the full consequences of COVID-19 were known, before the pandemic ripped through the health care system and left it in tatters.

The law requires patients asking for MAID to be informed of possible treatment options that might alleviate their suffering. But this assumes those are readily available. Instead, wait times to see mental health clinicians have only increased.

Psychotherapy, a recommended treatment for most mental disorders, remains too expensive for many Canadians. In Toronto alone, an estimated 16,000 people are waiting for supportive housing for mental illness and addiction.

In Ontario, nearly 6,000 patients with the most severe mental disorders are on a years-long list for specialist community-based care.

The rising cost of rent and food is also taking a particular toll on people with chronic mental illness, who are often already the poorest in society – and the very candidates who will qualify for assisted dying under the new law.

Just as life is getting harder in Canada, it is getting easier to die.

For advocates, expanding MAID is about not discriminating between mental and physical health, about seeing patients as whole people capable of making their own decisions.

Critics, on the other hand, suggest that MAID will become an easy out for a broken health care system, offering death rather than hope and treatment to society's most vulnerable and marginalized citizens.

Whether Canadians have fully debated where we stand as a society on these moral and medical questions is almost immaterial at this point.

With March red-circled on the calendar, Canada is speeding toward its own unique life-or-death experiment. The country needs to make sure that expanding MAID is safe for patients.

Do we have time to get it right?

'After all is said and done, the paramount issue is: what does the patient want to do?' says Derryck Smith, a member of the Canadian Psychiatric Association's assisted-dying committee. Dr. Smith is among a relatively small group of psychiatrists currently involved in Canada's MAID process. ISMAIL FERDOUS/THE GLOBE AND MAIL

When MAID was first legalized in 2016, it came with a narrative that was comforting to many Canadians: faced with a painful, imminent death, patients – most of them in their senior years – would choose, after a conversation with their doctor, to die on their own terms, peacefully, with dignity, and surrounded by their family.

As the number of Canadians receiving MAID has steadily increased, this narrative has remained largely true. In 2021, there were 10,064 assisted deaths in Canada – an increase of 32 per cent over 2020. The average age of Canadians who received MAID last year was 76. Two-thirds have a cancer diagnosis, and nearly one fifth have a heart condition.

They tend to be wealthier Canadians – more likely, as an Ontario study found, to fall into the highest income bracket than the lowest. They have been, in other words, people of relative privilege, wanting the same control in death that they had in life.

Testifying in support of MAID's expansion last spring, Derryck Smith, a B.C. psychiatrist, shared the example of a woman in her 40s who he assessed for MAID. She was the daughter of a judge, he said, who had struggled with anorexia for years. No treatment had worked; private clinics in the United States had failed to help. She had been hospitalized and tube fed against her will. She vowed to go home and starve herself if she wasn't approved for MAID. Reluctantly, her father, interviewed by Dr. Smith, agreed to support her decision. Her condition was deemed incurable, her suffering intolerable, and she received an assisted death.

Dr. Smith, who sits on the assisted dying committee for the Canadian Psychiatric Association, and is a member of the Canadian Association of MAID Assessors and Providers, falls on the patient autonomy side of the debate. He acknowledges that the health care system is broken and underfunded. But he argues that if a person is capable of consenting, meets the legal requirements, and wants to die, it would be morally wrong to deny their right to choose. Otherwise, those patients are truly trapped: they can't get timely treatment to alleviate their suffering, and they can't choose to end that suffering themselves.

"After all is said and done," Dr. Smith said, "the paramount issue is: what does the patient want to do?"

Mona Gupta, head of the federal expert panel, told the parliamentary committee last spring that excluding MAID for people with mental illness, "suggests that, as a society, we don't believe that people with mental disorders can really ever be capable of making their own decisions for themselves."

But this ethical argument raises another: Can a person freely choose to die if they don't have an equal chance to live with dignity?

Unlike the judge's daughter, people with chronic and severe mental illness are not typically travelling out of country for top-tier private care; many of them will not even have family doctors, let alone regular contact with specialists.

Compared to the general population – and compared to the Canadians currently getting MAID – they are significantly more likely to be unemployed and homeless. Their stories will often be complicated by trauma, childhood abuse, and addiction – their symptoms compounded by financial stress and loneliness.

Rather than worrying about equal opportunities in death, says Sonu Gaind, chief psychiatrist at Humber River Hospital, society should first correct the wrongs his patients face in life.

"This is about the autonomy of the privileged at the expense of the marginalized," he says.

In the Netherlands, where euthanasia for both physical and psychiatric illness has been legal for 20 years, studies have found that patients who receive an assisted death for a mental health disorder tend be younger and poorer than those with a physical illness.

They are also significantly more likely to be women – a statistic that has raised concerns among suicide prevention experts. In the Netherlands, as in Canada, men and women receive euthanasia for physical illness in roughly equal numbers. But for psychiatric euthanasia, Dutch women outnumber men roughly two to one. Researchers point out that this pattern aligns with another statistic: although death from suicide is higher among men, women are twice as likely to attempt suicide. One of the reasons for this difference is women tend to choose less-lethal means. The concern that experts raise, then, is that state-sanctioned assisted dying – without careful safeguards – may give women, in particular, access to a more socially acceptable but lethal method of suicide.

This is why the debate is so emotional for many doctors: they fear that people will die before they have chance to recover.

With the rising cost of food and housing, and wait times for treatment increasing, mental health advocacy groups have raised concerns that assisted dying will become an option for some of the most vulnerable Canadians just as life in Canada is getting harder.IAN WILLMS/THE GLOBE AND MAIL

The current MAID law in Canada establishes two tracks of patients – those whose death is reasonably foreseeable, and a second who have “grievous and irremediable conditions” that aren’t terminal and whose suffering is intolerable. In both cases, people must be 18, found capable of making a decision, and be approved by two doctors. For cases that aren’t terminal, there is 90-day waiting period after approval, and one of the assessors must be a specialist in the patient’s conditions.

The problem is the law calls for medical findings that are still fiercely debated in research. And even in practice, psychiatrists seeing the same patient don’t always reach the same conclusions. For starters, there’s no clear consensus about whether doctors can tell the difference between a patient who is making a rational, independent request for MAID and one who wishes to die from suicide because of their mental disorder.

Defining “irremediability” is even more contentious. Unlike cancer, doctors can’t rely on lab tests and brain scans to diagnose mental illness. Predicting what will happen to an individual patient with a mental illness is even harder because the outcome of psychiatric disorders isn’t reliably connected to how long – or how severely – someone is sick.

A 2016 large-scale American study, for instance, followed people with mental illness for 12 years – and found that the chances of recovery actually increased over time. Last month, a paper published in the journal Psychological Medicine reviewed the existing research on predicting outcomes for treatment-resistant depression; while computer algorithms and doctors in some smaller-scale clinical trials were better at determining outcomes, in the study that most closely replicated real-world conditions, psychiatrists got it right only about half the time. When it comes to psychiatric euthanasia, the authors concluded, “the object standard for irremediability cannot be met.”

Even the expert panel reporting back to Parliament concluded that “it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual

patient." (The panel itself wasn't immune from controversy: before it could finish its report, two of the 12 members had resigned, citing ethical reasons.)

Christie Pollock, a 31-year-old university student in Vancouver offered her own story as a cautionary example in a written brief she submitted to the parliamentary committee. For more than a decade, she said, "I had lost all hope of getting better." She has been diagnosed with a long list of disorders, including borderline personality disorder, severe anxiety, depression and a panic disorder. Since she was a teenager, she's seen a dozen different therapists and tried many different medications. Nothing worked. She overdosed four times, and was hospitalized repeatedly. But then, after years of trial and error – and doctors, she said, who refused to give up on her – she found the right combination of medication and therapy.

Today, she is studying psychology and facilitates a support group; her symptoms are manageable. She has a life that she never imagined for herself. If MAID had been available, she wrote in her brief, "I might simply be a memory."

But medicine, Dr. Gupta told the parliamentary committee, is a discipline largely guided by probabilities. "We can never remove all uncertainty," she said. She pointed out that doctors are already assessing health issues, such as chronic pain, with unclear outcomes. In the end, the expert panel found that it wasn't possible to come up with fixed rules about how many and what kinds of treatments a patient should get before receiving MAID. Instead, the panel recommended that a doctor establish incurability by assessing the treatment history, and length and severity of the illness.

In other words, critics counter, the panel proposed that doctors study a patient's past to predict their future – the very method disputed in research. John Maher, a psychiatrist in Barrie, Ont., asked the parliamentary committee, "How many mistakes are you prepared to make?"

Dr. Li has administered MAID before and shaped the protocols for other practitioners in Toronto's University Health Network. IAN WILLMS/THE GLOBE AND MAIL

In October, Madeline Li, a psychiatrist at Princess Margaret Cancer Care in Toronto, appeared on Zoom before the parliamentary committee. Her tone was soft – the voice of someone used to soothing dying patients – but her message was clear. The current MAID law, she said, gives too much power to doctors to make their own value judgments about what makes life worth living. The legislation needed more clarity to guide assessments. Cases needed to be more carefully reviewed after patients died to make sure the process was safe.

At the hearings, MAID providers have insisted the process is careful and rigorous, even more so for cases where death is not foreseeable. The number of people who seek MAID solely for mental illness will be small, they assured the committee, and the number approved from that

group even smaller. They point to the Netherlands, for instance, where psychiatric euthanasia, though increasing steadily over the last decade, still accounts for a tiny fraction of all cases. A larger issue, they say, will be offering equal access across the country, and ensuring there are enough psychiatrists to provide timely assessments for patients who want them.

But among the many experts who have lined up to express their objections to the direction and pace of Canada's euthanasia laws, Dr. Li's deserves particular attention. She led the creation of MAID protocols at the University Health Network, a group of Toronto-area hospitals that together form the largest health research group in the country. At the national association for MAID providers, she is the scientific lead currently developing the government-funded assisted-dying curriculum for doctors. She has administered assisted deaths directly to patients, and provided oversight to hundreds of cases as the MAID program lead at the UHN.

All that experience, she said in an interview, has made her personally opposed to expanding MAID for patients without a foreseeable death, especially those with mental illness. The debate among doctors has become too ideological, she said, and the current system doesn't have enough safeguards to prevent unconscious bias from factoring into decisions.

Can doctors – a mostly healthy, privileged group of people living in a society that routinely stigmatizes people with disabilities – objectively judge what makes life worth living? Dr. Li says she once watched a doctor use an actuarial chart to calculate that an older woman seeking MAID after a fall had, on average, three years left to live; he approved her for MAID, over the objections of three other physicians. "What if it had been six?" she asked. "How many years is enough?"

Dr. Li worries that since many psychiatrists won't participate in MAID, there will be "an echo chamber of a few assessors who will all practice in the same way," leaning hard toward patient autonomy. Already, she argues, MAID assessments are too often focused on whether a patient is eligible for an assisted death, rather than exploring why a patient wants to die in the first place.

The federal expert panel recommended that decisions should be made on a case-by-case basis, with the doctor and patient reaching a shared understanding. But while the law requires that patients must give "serious consideration" to clinically recommended treatments to relieve their suffering, they can refuse those treatments if they don't deem them "acceptable."

For instance, Dr. Li described the case of patient in his 30s, who asked for an assisted death, even though multiple doctors said his cancer was curable. Two assessors approved him for MAID. Faced with his adamant refusal to get treatment, and his progressing condition, Dr. Li said she helped him die "against her better judgment." If MAID didn't exist as an option, she believes he would have gotten treatment, and still be alive.

Since finding the right treatment for a complex mental disorder takes time, and conditions such as depression often make patients pessimistic about the future, clinicians have raised concerns about being pressured to approve MAID, even when they believe a patient might reasonably recover. There is also no limit on how many times a person can be assessed, raising worries that patients will "shop around" until they get approved.

Of course, a bigger issue than patients refusing treatment is what happens when the treatment that might help them recover isn't available. The current law requires that a person seeking MAID be offered consultations with professionals who provide recommended treatments, and the expert panel specifically suggested that they should include social services, such as housing. But often a doctor can't easily find those services, or a patient can't afford them. Already there have been controversial cases of Canadians requesting MAID, at least in part, because they couldn't get enough home care or access proper housing.

In a telling exchange at the parliamentary committee, Dr. Maher argued that a system that cannot provide care should not offer death as an alternative. For instance, he said some patients will have to wait five years to get the kind of specialty care he offers. "Telling my patients that you will make it easier for them to die has enraged me," he told the committee. "They will die because psychiatrists will now have legal permission to give up."

Testifying on the same day, Ellen Wiebe, a MAID provider in B.C., said that if a patient told her that they weren't willing to suffer five years while waiting for treatment, "then I would say that was irremediable."

People with chronic and severe mental illness are more likely to be poor and homeless than the general population. In Canada, there have already been examples of people seeking an assisted death, in part because of a lack of social services such as affordable housing.IAN WILLMS/THE GLOBE AND MAIL

For lessons, Canada can look to the few countries with a longer history of psychiatric euthanasia. In both Belgium and the Netherlands, front-line clinicians have warned other countries to proceed carefully.

In Belgium, for instance, some psychiatrists have argued for a two-part system – one that assesses patients for assisted dying, a second that independently investigates treatments to help them recover.

In the Netherlands, although the law does not specify standards of care, the Dutch Psychiatric Association has created clear guidelines, which, in particular, require two independent psychiatrists to assess a patient. (In Canada, the law currently requires only one specialist.) The second opinion is meant to explore possible treatment options, explains Sisco Van Veen, a psychiatrist at Amsterdam University Medical Center who assesses people for euthanasia, and also researches the issue.

Unlike the current law in Canada, which makes the acceptability of treatment ultimately the patient's decision, Dr. Van Veen says that if psychiatrists deem "the treatment refusal to be unreasonable they will deny the euthanasia request." In cases where psychiatrists disagree, a doctor who goes ahead with an assisted death must justify that decision in writing. Expert regional committees review every case, and publish detailed findings online.

The cases of psychiatric euthanasia in the Netherlands, while still relatively rare, began rising in 2012 with the opening of an end-of-life clinic. Psychiatrists there now handle the vast majority of cases. For about 90 per cent of patients who apply, an assisted death does not happen – the majority are deemed ineligible, Dr. Van Veen said, but a significant number also change their minds or get adequate treatment. Of course, proportionate to Canada, the Netherlands spends significantly more on mental health care.

Another issue to consider is how to make the assessments as thorough as possible. In the Netherlands, the clinic requires patients to sign a waiver making all relevant medical records available, and allowing communication with the doctors who have treated them, says Dr. Van Veen. Family caregivers are also usually interviewed, except in cases of abuse. Doctors can deny a euthanasia request if relatives are not involved.

The Dutch approach isn't perfect, and there are still controversial cases. But it shows how, with careful steps, a euthanasia system can also save some patients.

In 2020, Dr. Van Veen co-authored a paper about a Dutch patient who, for eight years, had been hearing childhood songs playing daily on repeat in his head. Among his collection of diagnoses, he had a history of psychotic episodes from schizophrenia.

Medication to quiet the songs had not worked and, at 36, he finally asked for an assisted death at the end-of-life clinic. Doctors there assessed him over the course of a year, and then sent him to an independent psychiatrist – a specialist in schizophrenia – for the required second opinion. That doctor, after a careful clinical investigation, proposed a different cause for the songs, and prescribed a new drug, along with psychotherapy.

Within weeks, the patient was in full remission. At the time his case written up, the patient had withdrawn his request for euthanasia.

"It was a close call," says Dr. Van Veen.

You can draw one of two conclusions from this cautionary tale, he said. Either psychiatric euthanasia cannot account for uncertainty, and thus should never happen. Or a system with clear safeguards works.

The final decision

Konia Trouton, a physician and MAID provider in Victoria, reflects on the solemn dance she performs with her patients – who are always in the lead.

Jane Hunter, a retired businesswoman who lives near Lake Simcoe, believes accessing MAID is her legal and moral right. She says she plans to be first in line come March. Her form is already filled out.

Long years of failed treatment and pill cocktails have worn the 73-year-old down. She is angry at doctors, who she feels dismissed her symptoms and ignored her trauma history. Now diagnosed with complex PTSD, she says she is tired of the side effects of the medication, of living alone with constant sadness and terrible memories. Divorced with no kids, most of the people in her life have walked away. In April, she says she attempted suicide twice. Now she is holding out, she says, for a dignified death with MAID.

“I am in constant pain, and I don’t want to live. Why would anyone question that?” There are things she will miss: the warmth of the sun, her garden in the summer. Death isn’t a joyful choice, but to stop her suffering she is adamant: it is her choice to make.

Perhaps society, by putting into place Bill C-7, shows it agrees. But laws and standards should still protect the complicated patients, the ones who have no advocates and few advantages, whose case history is complex, who might not want to die if they had a house and a job, and a life with meaning. And a system can’t just promise to be safe; it must also prove it – with diligent, and transparent oversight.

Canada needs to find a “muddy middle,” says Dr. Li. But that’s a complicated place, one the country seems unlikely to find by March.

Certainly, experts argue, doctors should know what recommendations will be accepted, what specific standards will guide them, what training they can get – ideally well before the first patient arrives in their office next year.

“It would be helpful to have more time to have these discussions,” says Tarek Rajji, chief of the Adult Neurodevelopment and Geriatric Psychiatry Division at CAMH, who co-signed a committee brief in May calling for a delay. He said that doctors need more clarity on how to make assessments so that decisions are consistent, and complicating factors such as a patient’s social context are properly considered. Most significantly, he said, there has not been enough consultation with actual patients and their families – the Canadians who will ultimately bear the burden of an assisted death. But, since a postponement seems unlikely, at this point, CAMH is currently working on a hospital-wide policy to be ready for March.

Expanding MAID isn’t only a medical debate, ethicists point out – it has cultural consequences that may seep, over time, into how we measure intolerable suffering, what investments we prioritize in health care, the value we place on certain lives, our definition of a good death. The debate won’t end with mental illness – as part of its mandate, the parliamentary committee is also hearing testimony on whether to give mature minors access to MAID, and how to allow advanced requests, particularly for Canadians with dementia.

“For a society to be able to look itself in the mirror in 100 years,” cautions Dr. Van Veen, from Amsterdam, “we really have to be careful.”

Meanwhile, in Ottawa, Ms. Leblanc wavers back and forth on whether to apply, depending on the day. Her new psychiatrist has adjusted her medication. She's on a waiting list for a group therapy program. But winter is coming, and that's the hardest season. "I am trying to find hope," she says. "But it will be dangerous to have MAID in my pocket."

Sometimes, she feels betrayed, as if society is giving up on her. Another part of her feels thankful. "Finally they are paying attention," she says. "It validates that my pain is real."

If you are having thoughts of suicide, call Kids Help Phone at 1-800-668-6868 or Crisis Service Canada at 1-833-456-4566, or visit crisisservicescanada.ca.

Assisted dying in Canada: More from The Globe and Mail

VIDEO: THE DOCTOR'S LAST WORDS

Ronald Bayne had an assisted death on Feb. 26, 2021, after a battle with bladder cancer. He spoke with The Globe and Mail about how his pioneering work in Canadian long-term care informed that choice.

THE GLOBE AND MAIL

COMMENTARY

Ellen Cohen: Why I resigned from the federal expert panel on MAID

Ebru Kaya and Leonie Herx: Assisted dying must not be confused for palliative care

André Picard: We must make it easier to both live and die with dignity, but denying MAID to those living in poverty is not the answer

Robyn Urback: Canada's assisted dying laws could use additional safeguards

Editorial: Medical assistance in dying is a right that needs more limits

COUNCIL MEETING –DECEMBER 14, 2022

NOTICE OF MOTION FOR APPROVAL

SUBJECT: **STANDARD OF PRACTICE – SOCIAL MEDIA**

BACKGROUND:

A Strategic Organizational Priority is to review and update the Standards of Practice and Practice Directions. While reviewing the order of working through the existing documents, it came to the attention of staff that CPSM does not have a Standard of Practice for Social Media which is sorely lacking. Both CPSO and CPSBC have, in 2022, revised their Standards on Social Media. This is important because it reflects the use, the many doctors made of social media posts during the pandemic (both good and bad).

As all of you are aware it is a tremendous amount of work to create new Standards of Practice as a smaller jurisdiction. Given the nature of social media and its spread across borders, CPSM staff consider there is nothing unique in Manitoba to require a made in Manitoba Standard and much can be adapted from these two Standards. This was discussed with the Executive Committee who endorsed the approach of a condensed Working Group and utilizing the other provinces' standards on social media.

All Standards set clear professionalism expectations for members of regulated professions while engaged in their professional practice. While they have far more latitude in their private affairs, they are not entitled to *carte blanche*. A higher standard of ethical conduct is expected of regulated professionals even in their private sphere. Specifically, conduct that reflects negatively on the reputation of the profession or diminishes a member's professional standing can attract regulatory oversight and possibly disciplinary action.

The demarcation between professional and private life is not always clear. There can be overlap. For example, some might consider certain engagement by a physician in social discourse relevant to the practice of medicine as falling into their professional sphere. For registrant's of CPSM, private and professional spheres often overlap where people take to social media to comment on the subject matter of their profession. This can have an impact on the reputation of the profession, the public's confidence in the professional, and the professional standing of the person commenting.

In the medical profession the distinction under the RHPA is between "*professional misconduct*" which relates to misconduct in one's professional practice and "*conduct unbecoming*" which more relates to dishonourable or morally reprehensible conduct in the professional's private life.

CPSM Staff utilized the two BC and Ontario Standards (heavily weighted on the latter province) and drafted a new version for Manitoba. A Working Group was convened consisting of several physicians who are prolific posters on social media in relation to healthcare, a resident member of Professional Association of Residents and Interns of Manitoba, and several physicians from the university involved in professionalism and ethics, in addition to public representatives. Two virtual meetings were held and the Working Group is now in the position to recommend that the draft Social Media Standard of Practice be distributed to the public, registrants, and 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

The public interest is best served by having minimum requirements for CPSM registrants in recognition of the important role social media plays in communication, advocacy, education, and professional development. Social media present important societal health opportunities such as enhancing public education, furthering patient safety, and encouraging access to care amongst other benefits.

Physicians hold a respected place in society. While using social media, professional conduct and communication are important to avoid harm to the public, not adversely impact patient care, preserve the reputation of the profession, and foster a culture of respect.
Regulators in several provinces had to address anti-vaxxing and COVID denying social media posts by registrants. Regulators are also not infrequently called upon to review the social media posts that registrants make in a very wide set of circumstances.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON DECEMBER 14, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The attached Standard of Practice – Social Media be distributed to the public, stakeholders, and registrants for consultation.

Standard of Practice

Social Media

DRAFT

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

Social media plays an important role in communication, advocacy, education, and professional development between registrants, patients, and the public. Many registrants use social media in their practices to interact with colleagues, seek out medical information on-line, and share content with a broad public audience. Social media presents important societal health opportunities such as enhancing public education, furthering patient safety, and encouraging access to care among other benefits.

Physicians hold a respected place in society. While using social media, professional conduct and communication are important to avoid harm to the public, not adversely impact patient care, preserve the reputation of the profession, and foster a culture of respect.

As a guiding principle, registrants are reminded that, irrespective of whether participating in social media is for a personal or professional purpose, prevailing expectations of professional and ethical conduct are the same as when interacting with others in-person. CPSM recognizes that registrants have rights and freedoms under the *Charter of Rights and Freedoms,* including the freedom of expression, subject to reasonable limits.

Definition

Social media includes online platforms, technologies, and practices used to share content, opinions, insights, experiences, and perspectives.[1]

[1] Examples of social media include Facebook, LinkedIn, YouTube, Twitter, and discussion forums. While it excludes Cortext which is the secure communications platform for healthcare for health care coordination, most of the Professionalism, Relationships, and Boundaries Sections are applicable to communications on Cortext.

1. Application

1.1. This Standard applies to the professional use of social media, but it can also apply to personal use depending upon several factors, for example, the connection between the physician's conduct and their professional role.

2. Professionalism, Relationships and Boundaries

2.1. Expectations of professional and ethical conduct are the same whether registrants are interacting in person, or online through social media.

2.2. Caution must be exercised when posting personal information on social media platforms. Assume content on the internet is public and widely accessible to all, and that closed groups may not be truly closed, or the contents may be re-posted.

2.3. Registrants must avoid engaging in conduct on social media that diminishes their professional standing or the reputation of the profession. This requires careful consideration of the potential consequences of their use of social media, both intended and unintended, and how their conduct might reasonably be perceived by others.

2.4. When using social media, registrants must:

- 2.4.1. maintain clear boundaries with patients in accordance with the *Sexual Boundaries with Patients, Former Patients, and Interdependent Persons.*
- 2.4.2. maintain professional and respectful communications with colleagues, other members of the health-care team, residents, medical students, and the public.
- 2.4.3. Uphold the standards of medical professionalism, conduct themselves in a professional manner, and not engage in disruptive behaviour[2] while using social media.
- 2.4.4. be mindful of and remain in compliance with all relevant professional, ethical, and legal responsibilities, including CPSM Standards of Practice and the *Code of Ethics and Professionalism*.
- 2.4.5. Consider the impact on and not exploit the power imbalance inherent in the relationships between physician-patient, physician-healthcare team members, physician-medical learners, and with the public.

[2] Disruptive behaviour includes inappropriate words, actions, or inactions that interferes with a registrant's ability to collaborate, the delivery of healthcare, or the safety (or perceived safety) of others. Disruptive behaviour may be demonstrated through a single act but is often identified through a pattern of events. Disruptive behaviour may include bullying, attacking, or harassing others and making discriminatory comments. An example of behaviour that is not likely to be considered disruptive includes constructive criticism offered in good faith with the intention of improving patient care of the healthcare system.

3. Privacy and Confidentiality

3.1. Registrants should avoid posting patient information if possible unless for educational purposes. Only post identifiable patient information or patient images to social media if the patient has provided a fully informed consent—even in a closed or private online forum. Once something is posted it is difficult to control further distribution and so consent to post these images should identify this as a risk. Treat photos and videos of a patient made in the context of patient care as part of the patient's medical record.

3.2. Registrants should refrain from seeking out a patient's (or former patient's) personal information from social media unless:
- 3.2.1. the information is necessary for providing health care;
- 3.2.2. there is an appropriate clinical rationale related to safety concerns;
- 3.2.3. they have considered how the search may impact the physician-patient relationship; and
- 3.2.4. document this in the patient record.

3.3. If relying upon patient health information found online for clinical decision-making, registrants must:
- 3.3.1. Take reasonable steps to confirm the information is accurate, complete, and up-to-date prior to using the information; and
- 3.3.2. If safe and appropriate to do so, disclose to the patient the source of the information, the clinical rationale, and any other relevant information.

3.4. Read, understand, and apply the most appropriate privacy settings to maintain control over access to information. Be aware that privacy settings are imperfect, can be compromised and may change over time.

4. Communicating Medical Information

4.1. When discussing health-related information on social media, registrants must be mindful about how the information might be relied upon, including considering the potential risk of creating a physician-patient relationship or creating the reasonable perception that a physician-patient relationship exists. Registrants must avoid establishing a physician-patient relationship and must not provide specific medical advice to individuals on social media. Remember that a duty of care may form when posting on-line medical advice.

4.2. If discussing general health information on social media for educational or information-sharing purposes registrants must:
- 4.2.1 ensure the information they present is verifiable by available, credible evidence and science,
- 4.2.2 acknowledge if they are challenging a widely-accepted position or proposing alternative theories which lack evidence and science, or if their position does not

represent the majority of the medical profession. In these circumstances, the clinical claims and information must not be false, misleading, deceptive, or be a potential threat to health.

4.2.3 be aware of and transparent about the limits of their knowledge, expertise, and scope of practice; and

4.2.4 not misrepresent their qualifications.

4.3. Advocacy - Many registrants utilize social media as a platform to advocate for system or societal change. While this is an essential role registrants must ensure that any advocacy efforts abide by the above provisions.

Contextual Information and Resources

Social Media

The Contextual Information and Resources are provided to support members in implementing this Standard of Practice. The Contextual Information and Resources do not define this Standard of Practice, nor should it be interpreted as legal advice. It is not compulsory, unlike a Standard of Practice. The Contextual Information and Resources are dynamic and may be edited or updated for clarity, new developments, or new resources at any time.

- Think before you post on social media.
- Maintain professional and respectful communications with colleagues, other members of the health-care team, and the public. Avoid derogatory, defamatory, or culturally insensitive statements and disengage from conversations that are disrespectful in tone and content. Defamatory statements published online (e.g. discrediting another registrant or health-care professional) may result in allegations of libel or slander.
- Be aware that plagiarism, copyright infringement and non-compliance with restrictive licensing agreements, trademarks, or terms of usage can lead to legal action. Always provide credit and links back to original sources when sharing information. Represent credentials accurately and declare conflicts of interest where applicable.

RESOURCES

CMPA

Good Practices Guide – Developing your digital presence

Top 10 Tips for using social media in professional practice

Advocacy for change: An important role to undertake with care

RECENT CASE LAW ON SOCIAL MEDIA

University of Manitoba undergraduate medical student posts on Facebook twice pro-guns posts and a lengthy anti-abortion/pro-life essay he authored. His expulsion from the University was overturned on matters relating to procedural fairness. Upon a re-review, the University expelled him again. Read further info

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Physician posts on a Physicians' Only Facebook group inappropriate remarks impugning the reputation of a colleague, for which they were censured. Read further info

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An RN highly criticizes her grandfather's medical and nursing care on Facebook and Twitter and was found guilty of professional misconduct by the regulatory body. The Court of Appeal found the off-duty conduct is subject to discipline by the regulator but overturned the decision because the regulator unjustly infringed the nurse's right to freedom of expression as the disciplinary panel failed to take a contextual approach in assessing whether the conduct was unprofessional. Read further info

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A plastic surgeon committed an act of professional misconduct by permitting a television crew to film a patient's surgical procedure without her informed consent, which resulted in a major breach of her privacy. He also failed to ensure the privacy of another patient as a result of the inadvertent posting of her images on social media on two occasions. He also posted before and after photos of the patients without consent. Read further info

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A couple more cases yet to come.