March 2022 Council Meeting

Wednesday, March 23, 2022| 8:00 a.m. |

AGENDA

In-Person CPSM Office

Time				Action	Presenter	Page #
5 min	8:00 am	1.	Opening Remarks		Dr. Elliott	
0 min	8:05 am	2.	Agenda – Approval		Dr. Elliott	
0 min	8:05 am	3.	Call for Conflict of Interest or In Camera		Dr. Elliott	
5 min	8:05 am	4.	Consent Agenda i. Council Meeting Minutes – December 8, 2021 February 17, 2022 ii. Practice Ready Assessment - Nuclear Medicine Approval iii. Practice Direction – Appeals inclusion in PD CC/IC Resolving Conflict & CPSM's CC/IC Process		Dr. Elliott	3
30	8:10 am	5.	Episodic, House Calls, and Walk-in Primary Care Standard of Practice	Approval	Ms. Penny Mr. Barnes	17
20	8:40 am	6.	M3P – Addition of Tramadol and Tramacet	Approval	Dr. Ziomek Dr. Reinecke	28
10	9:00 am	7.	Reference to Registrant in CPSM materials	Approval	Dr. Elliott	38
10	9:10 am	8.	Break			
90	9:20 am	9.	TRC Advisory Circle Update	Information	Dr. Monkman	40
10	10:50 am	10.	Strategic Organizational Priorities • Prescribing Practices Review	Information	Dr. Ziomek	44
10	11:00 am	11.	Committee Reports (written/questions) i. Executive Committee ii. Finance, Audit & Risk Management Committee iii. Complaints Committee iv. Investigation Committee v. Program Review Committee vi. Central Standards Committee	Information	Committee Chairs	46
15	11:10 pm	12.	Registrar's Report	Discussion	Dr. Ziomek	52

Time				Action	Presenter	Page #
10	11:25 pm	13.	Lunch (during in camera discussion)	Discussion	Dr. Elliott	
25	11:35 pm	14.	In Camera • Review of Evaluation of Governance Process • Registrar Performance Management Deliverables 2022 • Self-Evaluation of Council		Dr. Elliott	60
	12:00 pm	15.	Estimated time of session – 4 hours			

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 23, 2022
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: Consent Agenda

BACKGROUND:

Council used to utilize consent agendas to expedite its meetings and ensure the time spent at the meeting is productive, focussed on governance and fulfilling its mandate.

In order to make Council meetings more efficient and effective the consent agenda will be re-introduced. Routine and non-contentious business has been consolidated into a 'consent agenda'. Many organizations and their committees use consent agendas. Some Councillors may not have encountered a consent agenda previously. How the consent agenda works:

1. The President decides which items will be placed on the consent agenda. The consent agenda will appear 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.

Any item can be removed from the consent agenda if notice is provided to the President at least 24 hours prior to the meeting of Council.

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

i. Council Meeting Minutes – December 8, 2021
Council Meeting Minutes – February 17, 2022

ii. Practice Ready Assessment – Nuclear Medicine Approval

iii. Practice Direction – Appeals from Investigation Committee Decisions

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 23, 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
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Website: www.cpsm.mb.ca

MINUTES OF COUNCIL
December 8, 2021

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on December 8, 2021.

1. CALL TO ORDER

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

COUNCILLORS:
Ms Leslie Agger, Public Councillor
Ms Dorothy Albrecht, Public Councillor
Mr. Chris Barnes, Associate Member
Dr. Kevin Convery, Morden
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Dr. Ravi Kumbharathi, Winnipeg
Dr. Daniel Lindsay, Selkirk
Ms Lynette Magnus, Public Councillor
Dr. Wayne Manishen, Winnipeg
Dr. Norman McLean, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Charles Penner, Brandon
Ms Leanne Penny, Public Councillor
Dr. Ira Ripstein, Winnipeg
Dr. Mary Jane Seager, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg
Dr. Heather Smith, Winnipeg
Dr. Roger Süss, Winnipeg – Via teleconference
Dr. Anna Ziomek, Registrar

REGRETS:
Dr. Brian Postl
Dr. Brett Stacey

STAFF:
Dr. Karen Bullock Pries, Assistant Registrar
Ms Kathy Kalinowsky, General Counsel
Dr. Ainslie Mihalchuk, Assistant Registrar
Mr. Jeremy de Jong – Item #5
Ms Karen Sorenson, Executive Assistant

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. WAYNE MANISHEN, SECONDED BY MS MARVELLE MCPHERSON:
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. ADOPTION OF MINUTES

IT WAS MOVED BY MR. ALLAN FINEBLIT, SECONDED BY DR. ERIC SIGURDSON:
CARRIED

- That the minutes of the September 29, 2021, meeting be accepted as presented.

5. STANDARD OF PRACTICE DOCUMENTATION IN PATIENT RECORDS STANDARD OF PRACTICE MAINTENANCE OF PATIENT RECORDS

The Working Group recommended that the two Standards of Practice be approved because documentation of patient medical health and maintaining the patient records are essential components of safe and competent medical care.

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

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

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

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

6. STANDARD OF PRACTICE OFFICE BASED PROCEDURES

This Standard establishes minimum practice requirements for medical procedures performed in physician offices or medical clinics that pose a higher risk to patient safety. Many of these procedures are not medically indicated, are privately paid for, and require a higher degree of regulation to protect patients, including aesthetic procedures.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MR. ALLAN FINEBLIT that:
CARRIED

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

7. COMPLAINTS/INVESTIGATIONS RESTRUCTURING

Dr. Karen Bullock Pries presented in detail proposed changes to the Complaints/Investigations process to enhance patient participation yet remain respectful of CPSM members. This restructuring will provide alternative dispute resolution and will enhance timeliness, communication, ease of access, transparency, and fairness. A very lengthy discussion ensued.

8. COMPLAINTS/INVESTIGATIONS PRACTICE DIRECTION

A new Practice Direction reflects the restructuring of the Complaints and Investigation processes. It recognizes most processes are prescribed by the RHPA and the Part 14 requirement for the separate Complaints and Investigations Committees is only applicable for CPSM which creates duplication of work, extends timeliness, and dissatisfaction for both the patient and CPSM member.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. CHARLES PENNER THAT:
CARRIED

1. Council hereby approves the Practice Direction Resolving Conflict and CPSM's Complaints and Investigations Processes, as attached, to be effective immediately.

2. Council hereby rescinds the current Practice Direction Complaints, Investigations and Appeals effective immediately.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MS LESLIE AGGER THAT:
CARRIED

CPSM seek a legislative amendment to Part 14 of the RHPA to eliminate the separate Complaints Committee and Investigation Committee for CPSM.

IT WAS MOVED BY DR. WAYNE MANISHEN, SECONDED BY DR. MARY JANE SEAGER THAT:
CARRIED

Council directs the Registrar to develop performance metrics for Complaints/Investigations and present these periodically to Council.

9. STANDARD OF PRACTICE EXERCISE CARDIAC STRESS TESTING

This Standard establishes the minimum requirements and qualifications for those members involved in this testing recognizing the need for patient safety.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY MR. ALLAN FINEBLIT that:
CARRIED

Council hereby approves the Standard of Practice for Exercise Cardiac Stress Testing, as attached, to be effective on June 1, 2022.

10. FINANCIAL MANAGEMENT POLICY

The Financial Management Policy requires reserves be established for Inquiry cases as a cost estimate of $200,000. This was amended recognizing that this amount was much higher than actual costs of Inquiry cases.

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

Section 1.8.1 of the CPSM Financial Management Policy be amended as follows:

1.8.1 To cover the potential costs of extraordinary number of inquiry cases based on historical cost that management will analyze on a periodic basis.

11. STRATEGIC ORGANIZATIONAL PRIORITIES

Councillors were presented with the Progress Chart for the Strategic Organizational Priorities and an update on priorities was provided.

12. CEO/REGISTRAR'S REPORT

In addition to her written report, Dr. Ziomek addressed the continued financial sustainability of CPSM, noting that revenue is derived from fees which have not increased for the last six years, while the scope, quantity, and quality of work has increased thereby leading to increased expenses.

13. 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

14. IN CAMERA SESSION

An in-camera session was held with and then without Dr. Ziomek in attendance. The President advised that nothing be recorded in the minutes.

There being no further business, the meeting ended at 12: 23 p.m.

_____
Dr. J. Elliott, President

_____
Dr. A. Ziomek, Registrar

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MINUTES OF COUNCIL
February 17, 2022

An in-camera meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on February 17, 2022 from 5:00 to 7:00.

COUNCILLORS:
- Ms Dorothy Albrecht, Public Councillor
- Mr. Chris Barnes, Associate Member
- Dr. Kevin Convery, Morden
- Dr. Jacobi Elliott, Grandview
- Mr. Allan Fineblit, Public Councillor
- Dr. Ravi Kumbharathi, Winnipeg
- Dr. Daniel Lindsay, Selkirk
- Ms Lynette Magnus, Public Councillor
- Dr. Wayne Manishen, Winnipeg
- Dr. Norman McLean, Winnipeg
- Ms Marvelle McPherson, Public Councillor
- Dr. Charles Penner, Brandon
- Ms Leanne Penny, Public Councillor
- Dr. Ira Ripstein, Winnipeg
- Dr. Mary Jane Seager, Winnipeg
- Dr. Nader Shenouda, Oakbank
- Dr. Eric Sigurdson, Winnipeg
- Dr. Heather Smith, Winnipeg
- Dr. Roger Süss, Winnipeg – Via teleconference

REGRETS:
- Dr. Brian Postl
- Ms Leslie Agger

STAFF:
- Dr. Anna Ziomek, Registrar
- Dr. Karen Bullock Pries, Assistant Registrar
- Dr. Ainslie Mihalchuk, Assistant Registrar
- Ms Kathy Kalinowsky, General Counsel
- Ms Karen Sorenson, Executive Assistant

Council met in-camera to have a Blue-Sky meeting discussion and review the governance session report from Mr. Chisholm. Each member was asked to share their ideas on the future direction of CPSM. Individual items suggested fell under the categories of Mandate, Council – Governance, CPSM Resources, Possible Strategic Organizational Priorities, and Miscellaneous.

An in-camera session was held at the end.

_____
Dr. J. Elliott, President

_____
Dr. A. Ziomek, Registrar

COUNCIL MEETING – MARCH 23, 2022

CONSENT AGENDA ITEM

SUBJECT: Approval to include Nuclear Medicine Specialist Field of Practice for Assessment for the Purposes of CPSM General Regulation Section 3.38(b).

BACKGROUND:

Conditional and temporary registration may be granted for specialist fields of practice if the field is listed in the CPSM General Regulation s. 3.38(b). The College of Physicians and Surgeons of Manitoba General Regulation s.2.10(2)(b) 45. allows for the addition of "any other approved specialty field of practice".

If Council approves the addition of Nuclear Medicine to the Specialist Field of Practice for Assessment, a physician can be referred to the Division of Continuing Professional Development for an assessment in that area. The Section Head of Nuclear Medicine has confirmed their commitment to participate in the Practice Ready Assessment of a physician who is seeking registration with CPSM. The applicant has practiced medicine independently and has been registered as a specialist in this area of practice in another jurisdiction.

See attached letter from Dr. Reslerova, the Director of the International Medical Graduate Program at the University of Manitoba.

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 Practice Ready Assessment is an alternative route to specialist registration for many, including International Medical Graduates. An assessment, rather than full residency and examinations, can be used in circumstances to ensure through a rigorous assessment exercise over a lengthy period of time that the applicant has the competency to safely practice independently in Manitoba.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 23, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Nuclear Medicine be added to the Qualifications and Registration Practice Direction as a Specialist Field of Practice for Assessment for the purpose of CPSM General Regulation Section 3.38(b).

University of Manitoba | Rady Faculty of Health Sciences

Max Rady College of Medicine
International Medical Graduate Program
260 Brodie Centre
727 McDermot Avenue
Winnipeg, Manitoba R3E 3P5
Phone: 204-975-7757
Fax: 204-789-3911

December 7, 2021

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

Re: Practice Ready Assessment - Specialty Practice (PRA-SP) in Nuclear Medicine

I would like to report that Dr. Bohdan Bybel, with the Section of Nuclear Medicine, has confirmed their commitment to participate in the PRA-SP effective immediately.

I would therefore like to officially request that the College add Nuclear Medicine to the Approved Fields of Specialty Practice for Assessment for the Purposes of CPSM General Regulation Section 3.38(b).

Please let me know if you require any additional information or documentation to process this request.

Yours sincerely,

Martina Reslerova, MD, PhD, FRCPC
Director,
International Medical Graduate Program

MR/cc

cc: Dr. Bohdan Bybel, Section Head, Nuclear Medicine

COUNCIL MEETING – MARCH 23, 2022

CONSENT AGENDA ITEM

SUBJECT: Practice Direction – Appeals from Investigation Committee Decisions

BACKGROUND:

At its December meeting Council passed a new Practice Direction on Resolving Conflict and CPSM's Complaints and Investigations Processes. At the same meeting it rescinded the Practice Direction on Complaints, Investigations, and Appeals.

The new Resolving Conflict Practice Direction does not have a section on Appeals. In rescinding the previous Practice Direction, the appeals sections which were not carried forward into a new Practice Direction, simply vanished. An error was made at the time in not creating a separate Practice Direction for Appeals. A new separate Practice Direction for Appeals from Investigation Committee Decisions has been created. It is identical in content (other than numbering) as the previous appeal provisions in the Practice Direction. Practice Directions do not require consultation.

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 23, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The Practice Direction – Appeals From Investigation Committee Decisions be approved as attached.

PRACTICE DIRECTION
Appeals from Investigation Committee Decisions

Initial Approval: **Effective Date:**

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*.

This Practice Direction is made under the authority of s. 85 of the RHPA and represents requirements of CPSM members 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 members of the College 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 member; 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.

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 member.

2.2. Both the complainant and the investigated member 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 member.

5. Meeting

5.1. When an Appeal Panel meets to consider an appeal:
5.1.1. Neither the complainant nor the investigated member 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 member 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 member 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 - MARCH 23, 2022

NOTICE OF MOTION FOR APPROVAL

TITLE: Draft Standard of Practice – Episodic, House Calls, and Walk-in Primary Care

BACKGROUND

At its June 2021 meeting, Council established its upcoming Strategic Organizational Priorities. One of these is to develop a Standard of Practice for Episodic, House Calls, and Walk-In Clinics Primary Care. Continuity of primary care is fundamentally important for the delivery of good medical care. Much of the medical system requires each person having a family doctor to provide continuous medical care. Continuous medical care includes not only a longitudinal relationship between patient and physician, but also referrals to specialists, ordering of tests and follow-up, prescribing of long-term drugs, treatment of chronic medical conditions, and at times, multiple attempts to treat medical conditions.

However, not all persons have family doctors – whether due to a shortage of family doctors in the community, the patient not trying to obtain a family doctor, travel, or various other reasons. Some patients without family doctors seek medical care from alternative sources – walk-in clinics or other sources, including urgent care/emergency departments. Other patients may not be able to access their family doctor in a timely manner or at a time that is suitable for their schedule, so they resort to other alternative medical care delivery. This fragmented care can create challenges in providing good medical care.

Walk-In clinics have filled the void for many patients, whether due to the availability of same day clinical encounters, convenient hours (open weekends and evenings), convenient locations (maybe close to work or home), etc. Walk-in clinics play an important role in providing same day medical care to those who require it. These also can play an important part in providing medical care for those who are travelling (for instance, the patient from The Pas who is in Winnipeg and requires medical care for strep throat). Walk-in clinics are extensively used by university/college students and those new to Canada.

Some practice groups offer medical care on a same day walk-in or appointment with one physician in the practice group. That physician providing the episodic care will have access to the patient's medical charts and will also be familiar with the style of the usual family doctor. In those cases, the usual family doctor may or may not be responsible for follow-up and referrals.

The traditional model of a doctor attending bedside in the patient's home to deliver medical care has almost disappeared. Some family physicians may still offer house calls for long-standing patients in their time of need. And physicians working in the WRHA Access Centres run a house call service for their patients unable to attend the Access Centre. There are also limited house call services available in Winnipeg.

While many patients use house calls because they are too ill to attend at a medical clinic, many resort to house calls because of mobility constraints – whether due to disability, socio-economic, or other. For instance, anecdotally, one of the higher users of house calls is the single mother of multiple children who can avoid taking the entire family on a bus for an appointment of one sick child.

Some have accused walk-in clinics of churning patients quickly for financial gain. Like any care provided, it depends upon the individual physician.

To ensure good medical care in episodic, house calls, and walk-in clinics CPSM will develop a Standard of Practice for this type of care. Many other medical regulatory colleges in Canada have established rules to guide members in treating patients in episodic and walk-in clinics. There are no special rules for house calls, though some of that will fall under episodic care.

Working Group

The Working Group met on several occasions to prepare the Standard of Practice for Episodic, House Calls, and Walk-In Primary Care. The Working Group consisted of family physicians, a physician assistant, and two public representatives and was chaired by Ms. Leanne Penny. One of the members works partially in and owns a walk-in clinic, in addition to their regular family practice. Their insight into actual usage and experiences was particularly helpful for the Working Group to address concerns.

The Working Group questioned who uses these services? Why? And what concerns for good medical care should CPSM address in this Standard.

The Working Group recommends to Council that the attached Standard of Practice be distributed to the public, stakeholders, and membership for feedback.

The Standard

The Working Group was fortunate to be able to review the Standards of other jurisdictions and build upon their work.

The Standard applies to primary care only. CPSM already has a standard of practice for setting out the responsibilities and obligations for consultations. It does not apply to medical care provided in:

- Emergency and urgent care in hospital settings
- Long-term care facilities such as personal care homes
- Palliative and end-of-life care, including medical assistance in dying
- Consultations.

In addition to walk-in clinics and house calls, the Standard does apply to primary care delivered in unique facilities such as:

- PanAm clinic
- Minor Injury clinics
- Public health clinics – Sexually Transmitted Infections and contraceptive clinics

The Standard establishes requirements for:

- The standard of care
- Relationship with regular primary care providers
- Supporting patients to obtain a regular primary care provider
- Continuity of care and/or follow up care
- Prescribing matters
- Application of virtual medicine standard

It was important for the Working Group to address the issue of some distant rural and remote First Nations only having access to episodic care. The preamble contains the following statement of recognition.

> "CPSM recognizes that geographic impediments to accessing continuous primary care from members may exist for distant rural and remote and First Nations communities and that episodic and walk-in treatment may be the only medical care available."

Attached is the Regulatory Impact Assessment for this Standard of Practice.

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

This Standard is required to ensure the continuity of care in a fragmented primary care delivery environment. Critical to required good medical care is patient safety. The Standard requires that the medical care is provided in the patient's interest and recognizes the choice of patients in choosing the modality of care delivery. This Standard recognizes episodic, house calls, and walk-in clinic primary care plays an important role in the delivery of medical care, but additional guidance to the profession is required to ensure it is safe and good medical care providing for continuity.

The Standard recognizes the importance of episodic, house calls, and walk-in clinics in the delivery of primary care in many different circumstances throughout the province. The integration of that care with the primary care provider may be critical for good medical care.

POSSIBLE QUESTIONS FOR DISCUSSION

- Does this address the initial case of the Central Standards Committee that reviewed a case of medical care provided by a house call?
- Will this Standard improve the delivery of medical care in the province?
- Are there any aspects that will hinder medical care?
- Are likely patient concerns addressed in this Standard?
- Some patients may consider their walk-in clinic doctor to be their family doctor. How does this Standard address this?

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 23, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> The attached Standard of Practice - Episodic, House Calls, and Walk-in Primary Care be distributed to the public, stakeholders, and membership for consultation.

Standard of Practice

Episodic, House Calls, and Walk-in Primary Care 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

CPSM has responsibility to set standards and policies that result in high quality care for patients regardless of their point of contact with members in the health care system. For reasons of lack of access or convenience of hours, patients often turn to episodic services such as walk-in or ''no-appointment'' visits in clinics. Members are expected to manage these episodic encounters to provide optimal continuity of care for patient safety. CPSM recognizes that geographic impediments to accessing continuous primary care from members may exist for distant rural and remote and First Nations communities and that episodic and walk-in treatment may be the only medical care available.

The *Code of Ethics and Professionalism* provides the ethical basis for this Standard.

> *2. Having accepted professional responsibility for the patient, continue to provide services until these services are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient, or until after the patient has been given reasonable notice that you intend to terminate the relationship.*

DEFINITIONS

Episodic Care refers to a single primary care medical encounter with a patient focussed on presenting concern(s), identified medical conditions(s), where neither the regulated member nor the patient have the expectation of an ongoing care relationship.

Walk-in Clinic refers to medical practices that provide care to patients where there may be no existing association between the patient and the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature.

House Calls refers to a medical encounter performed by the member while visiting the patient's home (or property where residing including hotel, shelter, or temporary lodgings).

Part 1. APPLICATION

1.1 This Standard applies to primary medical care provided through episodic care, walk-in clinics, and house calls (including episodic care clinics such as PanAm Clinic, Minor Injury Clinics, Public Health Clinics including for Sexually Transmitted Infections, Contraceptive Clinic etc.).

1.2 This Standard does not apply to care provided in:

1.2.1. emergency and urgent care in hospital settings.
1.2.2. long-term care facilities such as personal care homes.
1.2.3. palliative and end-of-life care, including medical assistance in dying.
1.2.4. consultations with specialists. Standard of Practice Collaborative Care

Part 2. STANDARD OF CARE

2.1. Members must provide the same standard of care to patients irrespective of the practice setting in which such care is provided and irrespective whether the patient is, or is not, a regular patient of the clinic where the physician works.

2.2. Members must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner. For example, members practising in a walk-in clinic must conduct any assessments, tests, or investigations that are required for them to appropriately provide treatment. Members must also provide or arrange for appropriate follow-up care.

2.3. Members who limit the care or services they provide due to the episodic nature of their care must only do so in good faith.

2.4. Members must communicate any limitations to patients in a clear and straightforward manner; and communicate appropriate next steps to patients seeking care or services that are not provided, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care.

Part 3. PRIMARY CARE PROVIDER

3.1. Patients must be asked if they have a primary care provider who they usually see for care and, if so, that name must be recorded on the patient's record.

3.2. The clinic must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider identified by the patient unless patient consent is not granted.

Part 4. SUPPORTING PATIENTS

4.1. If primary care providers are present in the community, members must use their professional judgment to determine whether it would be appropriate to advise patients:
  4.1.1. That there are differences between episodic care and care that is provided as part of a sustained primary care provider-patient relationship; and
  4.1.2. About the benefits of seeing their primary care provider for care or encouraging them to seek one out, if they don't already have one.

4.2. The patient's choice in obtaining episodic, house calls, or walk-in care must be respected.

Part 5. CONTINUITY OF CARE AND/OR FOLLOW-UP CARE

5.1. A member must continue to assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the *Standard of Practice for Good Medical Care*. The medical care and follow-up is required unless the member has ensured that another primary care provider has agreed to provide this.

5.2. A member providing care must not rely on the patient's primary care provider or another health-care provider involved in the patient's care to provide or coordinate appropriate follow-up for tests they have ordered or referrals they have made, unless the other has agreed to assume this responsibility.

Part 6. PRESCRIBING

6.1. To mitigate risk of harm the member must use reasonable efforts (recognizing there may not be internet connectivity throughout the province) to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN as appropriate.

6.2. Members prescribing opioids, benzodiazepines, and Z-drugs, and authorizing cannabis must comply with the relevant *Standard of Practice for Prescribing Opioids*, the *Standard of Practice for Prescribing Benzodiazepines and Z-Drugs*, and the *Standard of Practice for Authorizing Cannabis for Medical Purposes*.

Part 7. VIRTUAL EPISODIC AND "WALK-IN" CARE

7.1. The Standard of Practice for Virtual Medicine is applicable to virtual episodic and walk-in care, in so far as possible.

CPSM Regulatory Impact Assessment

Standard of Practice – Episodic, House Calls, and Walk-in Primary Care

March 4, 2022

Background/Issue:

There is a need for CPSM to establish minimum practice requirements for those members providing care that is episodic, house calls, or in a walk-in primary care basis.

This an identified gap in the standard of care provided in a non-institutional environment. Fragmented care delivery often lacks the continuity of care required for the delivery of best medical care, yet there is a role for episodic, house calls, and walk-in care. This is especially because not all Manitobans have a family physician, the lack of availability of their family physician, inability to travel to the physician's office, travelling within the province or from another province, and convenience of hours amongst other factors.

This is a Strategic Organizational Priority for CPSM.

Proposed Solution:

Not Applicable ☐

There is a need for CPSM to have a Standard of Practice to establish minimum practice requirements for those members providing care that is episodic, house calls, or in a walk-in primary care basis.

Accountability:

Registrar

Timeline:

Fixed Timeframe

Not Applicable ☐

The Standard of Practice for Episodic, House Calls, and Walk In Primary Care is a Strategic Organizational Priority for 2021/22. If Council approves the draft recommended by the Working Group, then it will be in a consultation period in the spring. The Working Group will reconvene to review the feedback and will revise the document accordingly. The final Standard may be ready for Council to review at its September meeting, but if slightly delayed due to the summer holiday schedule, it will be ready for the December Council meeting.

On-going Not Applicable ☐

For the implementation of any Standard, there is a communication strategy prepared to ensure ease of implementation – both for the patients and for the profession. It is anticipated there will be numerous inquiries, both from patients and from the public as the new minimum requirements for care impact upon the delivery of care.

There will likely be several complaints filed as some of the profession may not adhere to the minimum care requirements.

Alignment of Organizational Priorities:

Not Applicable ☐

This is a Strategic Organizational Priority.

Patient Safety:

This Standard is required to ensure the continuity of care in a fragmented primary care delivery environment. Critical for required good medical care is patient safety. The Standard will ensure that the medical care is provided in the patient's interest. This Standard will recognize episodic, house calls, and walk-in clinic primary care plays an important role in the delivery of medical care, but additional guidance to the profession is required to ensure it is safe and good medical care providing for continuity. The Standard also requires the communication of this care with the family physician and has requirements for follow-up of care and tests. This communication between care providers is particularly important in the absence of a single electronic medical records system in the province.

Risk Analysis:

Public Risk Not Applicable ☐

The public expects good medical care to be delivered regardless of whether delivered by their family doctor, a house call, or a walk-in clinic or some other episodic care. Many patients do not understand the limitations of such care and may assume that there is continuity of care between their family doctor and the episodic primary care. Many patients do not realize that the care provided in a walk-in clinic is not full continuous primary care and may even consider that walk-in clinic their family doctor. CPSM must ensure registrants delivering this type of episodic primary care have responsibilities for communication with the family doctor and follow ups, and explain the limits of care to patients.

Reputational Risk Not Applicable ☐

Ensuring good medical care delivered by CPSM registrants is the core mandate of CPSM. Failure to meet the regulatory mandate could impact CPSM's reputation with the public, stakeholders, registrants, and government.

Regulatory Risk Not Applicable ☐

Similar to reputational risk, failing to meet the mandate of self-regulation in the public interest could place the privilege of self-regulation in jeopardy.

Operational Risk Not Applicable ☐

The operational risks are for those registrants with this type of primary practice, and not CPSM as an organization. The increased requirements for minimum care should cause some registrants to take longer in individual appointments and follow up communications and monitoring. There will be an administrative cost and time spent on sending information to the regular primary care provider. There is a remote possibility that the requirement may force some registrants who provide this type of care to only provide care for low complexity patients to avoid the responsibilities associated with patients requiring complex care.

Regulatory Impact on Members:

The impact will be greatest on those physicians who engage in primary care that is episodic, perform house calls, and work in walk-in clinics. If not already doing so, they will have to revise their practice to meet the standard of care that is the same across all delivery modes. They must conduct any assessments, tests, or investigations required for treatment and can only limit their care in good faith. There are also requirements for communication, supporting patients, and continuity of care and follow-ups.

These changes will provide improved care for Manitobans, and will require those delivering episodic care to deliver care at the same standard as others. This will likely take more time for each patient encounter.

Financial Impact:

Human Resources: Not Applicable ☐

Several physicians, legal counsel, and staff will likely respond to inquiries on this Standard if and when implemented. Those inquiries will come from both registrants and patients. It simply takes time to respond to each inquiry. With a Standard in place clearly outlining the minimum requirements for good medical care, if those standards are not met, then either the Quality or Complaints/Investigation Department will likely be required to address any allegations of deficiencies in care.

Financial: Not Applicable ☐

See above (in Human Resources).

Infrastructure: Not Applicable ☒

There may be some related IT infrastructure required from Digital Health to better track the care longitudinally even though the care is provided episodically (would help an Emergency physician when providing care if they knew what the patient went to a walk-in clinic for and what tests might have been ordered)

Transition Budget: Not Applicable ☒

Alternatives or Status Quo: Not Applicable ☐

If not implemented, then good medical care may be compromised with patient outcomes not being as good as they should be.

Evaluation and Outcomes: Not Applicable ☐

Improved patient care with enhanced communication with the regular primary care provider are desired outcomes. It will be difficult to evaluate this.

Additional Information: Not Applicable ☒

Recommendation:

Approve and implement the Standard of Practice for Episodic, House Calls, and Walk In Primary Care.

Submitted by:

Dr. Anna Ziomek
Kathy Kalinowsky

COUNCIL MEETING - MARCH 23, 2022

NOTICE OF MOTION FOR APPROVAL

TITLE: Addition of Drugs to Manitoba Prescribing Practices Program (M3P) – Practice Direction – Tramadol Products and Tramacet

BACKGROUND

Certain prescription drugs listed under the Manitoba Prescribing Practices Program (M3P) can only be prescribed on a prescription form approved by CPSM and are governed by more stringent prescribing and dispensing requirements. These drugs are listed on Schedule A to the Manitoba Prescribing Practices Program Practice Direction, which has been approved by Council. Changes to the M3P drug list must be approved by both Councils of the College of Physicians and Surgeons of Manitoba and the College of Pharmacists of Manitoba (CPhM).

Some councillors may recollect that in 2018 and 2019 Councils for CPSM and CPhM jointly removed Concerta, Vyvanse, Biphentin, and Foquest from the M3P Schedule and added Xyrem. Though prescribed for the treatment of cataplexy, Xyrem is known as a date rape drug and has enormous risk potential. The list of drugs included on the Schedule will change over time, as drugs are reclassified, subject to abuse in the community, or a danger to society.

At issue now are the two drugs – Tramadol and Tramacet. For the public representatives on Council, Tramadol is similar to an opioid analgesic and is used to relieve moderate to moderately severe pain, especially following surgery. The extended-release capsules or tablets are used for chronic ongoing pain. It can create dependencies – physical and mental. Tramacet is a mixture of both tramadol and acetaminophen.

Attached is the Briefing Note with attachments prepared by the CPhM. The Council of CPhM have passed a motion to include Tramadol Products and Preparations to the M3P list. CPSM is grateful to the CPhM for preparing this and permitting CPSM to use their documents.

If passed by both Councils, CPSM and CPhM will prepare a joint notice to the profession to advise of these changes to the M3P list of drugs. Consultation with the registrants and stakeholders is not required to amend a Practice Direction.

At the Council meeting, Dr. Reinecke will speak to this matter.

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

Patient safety is important for those drugs listed on this schedule and their prescribing is limited to protect patients and others from the risks inherent in these drugs.

Owing to Tramadol's and Tramacet's restricted use, high abuse potential, and new classification under the Controlled Drugs and Substances Act, both should be included on the M3P list for increased patient safety and the safety of others in society.

POSSIBLE QUESTIONS FOR DISCUSSION

- If the Prescribing Practices Review Working Group is considering eliminating the M3P, then why add more drugs to the M3P?
- Are both Tramadol and Tramacet of concern to the Chief Medical Examiner's Death Review Committee?
- Have Tramadol and Tramacet increased in prescription amounts since the introduction of the Standards of Practice for Opioids and Benzodiazepines and Z-Drugs?
- The College of Pharmacists of Manitoba's Council has already passed a similar motion. What happens if CPSM does not pass this motion as recommended?
- What are the implications on registrants if these drugs are on the M3P?
- Will patient access to these drugs be limited by this? Is this limitation good or bad for patient care and patient safety?

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 23, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Tramadol Products and Preparations be included on the M3P list

[redacted]

AGENDA ITEM # 12.b.

Date: February 22, 2022

To: CPhM Council

From: Meret Shaker, Practice Consultant – Legislation and Policy

RE: Health Canada Amendments under the *Controlled Drugs and Substances Act (CDSA)* to Scheduling of Tramadol and Consideration for Addition to the M3P Schedule

Decision Required

Issue

Tramadol is a synthetic opioid analgesic that has been marketed in Canada since 2005. It has been regulated under the *Food and Drugs Act* (FDA) Prescription Drug List since then and is available by prescription only. Unlike most opioids, tramadol was not controlled under the *Controlled Drugs and Substances Act* (CDSA) or regulated under the Narcotic Control Regulations (NCR).

On March 31, 2021, Health Canada published in the Canada Gazette, Part II, regulatory amendments that would control tramadol (including its salts, isomers and salts of isomers, and their derivatives) under Schedule I to the CDSA, and under the schedule to the NCR. They can be found at the following links:

- Order Amending Schedule I to the *Controlled Drugs and Substances Act* (Tramadol)
- Regulations Amending the Narcotic Control Regulations (Tramadol)
- Notice of intent to amend: Prescription Drug List (PDL): Tramadol

These regulatory amendments will come into effect on **March 31, 2022**. The Full Health Canada Regulatory Impact Analysis based on the public and stakeholder consultation held between April and June of 2019, can be found here https://gazette.gc.ca/rp-pr/p1/2019/2019-04-20/html/reg2-eng.html.

In addition to the upcoming Health Canada changes, the College of Pharmacists of Manitoba (CPhM) Council is asked to consider adding tramadol products to the Manitoba Prescribing Practices Program (M3P) drug list, similar to other Schedule I CDSA drugs, and drugs listed on the Schedule to the NCR.

Background

According to information provided within the Health Canada Regulatory Impact Analysis:

> "Like other opioid analgesics, while tramadol can provide effective pain relief for some patients, it has potential for problematic use, and chronic use of tramadol can lead to tolerance and dependence. Tramadol

can also cause harmful adverse effects that pose risks to human health, which can be fatal in some cases. Tramadol is suspected to have contributed to 27 reported deaths in Canada between 2006 and March 2020.

The crisis of overdoses and deaths caused by opioids is of national concern in Canada. Canada is the world's second-largest consumer of prescription opioids per capita, and there have been increasing concerns related to prescription opioids due to their potential for diversion and problematic use, both within Canada and globally. While problematic use of tramadol has not contributed significantly to the opioid crisis in Canada, it is a significant and growing public health concern in other countries and is a potential threat to the health and safety of Canadians.

Controlling tramadol under the CDSA and NCR will strengthen Health Canada's oversight of legitimate activities with tramadol, facilitate detection and prevention of diversion, and help to mitigate the risk of problematic tramadol use emerging as a significant threat to the health and safety of Canadians."

According to the Health Canada Drug Product Database, there are currently 18 marketed products (each with several strengths) with the active ingredient tramadol:

- Ten (10) are single ingredient tramadol products; and,
- Eight (8) are combination products with acetaminophen.

Once the Health Canada amendments are in force on March 31, 2022:

1. Patients will continue to obtain tramadol pursuant to a prescription, but verbal prescriptions and refills* will no longer be permitted
    a. **Note:** *only part fills with total quantity and specific time intervals will be allowed
2. Prescription transfers of tramadol products will no longer be permitted
3. As per the Office of Controlled Substances Bulletin (*appendix i*) pharmacies will be required to:
    a. maintain, in an auditable manner, all the records required by the NCR regarding their activities with tramadol for a minimum of two years. This includes, but is not limited to the following records:
        1. Purchase records
        2. Records of receipts
        3. Sale/Provision records
        4. Emergency transfer records
        5. Records of returns to licensed dealers
        6. Destruction records
    b. include all tramadol prescriptions dispensed on or after March 31, 2022, in their special narcotic prescription file, including all part-fills based on prescriptions received prior to the scheduling change.
    c. include all tramadol products in their quarterly CDSA inventory counts and reconciliation.
    d. post-consumer returns or unserviceable stock containing tramadol must be destroyed according to the instructions provided by Health Canada.
    e. not sell or provide tramadol to a pharmacist or a practitioner that is named in a notice of restriction on which narcotics are listed, except when dispensed to them as a patient. Furthermore, a pharmacist cannot dispense a prescription for tramadol signed by a practitioner who is named in a notice of restriction for narcotics. Additionally, pharmacists named in a notice of restriction on which narcotics are listed will not be able to purchase tramadol from licensed dealers or from other pharmacists for emergency purposes.
    f. report all losses and thefts of tramadol products to Health Canada and CPhM within 10 days of discovery.

The federal changes affecting tramadol products will present the most significant changes to current prescribing and dispensing practices with respect to tramadol products (i.e., no verbal orders, no transfers, record keeping,

etc.) Beyond that, the addition of tramadol products under the provincial M3P program will introduce minor additional restrictions to prescribing and dispensing (i.e., must use approved M3P forms).

Considerations

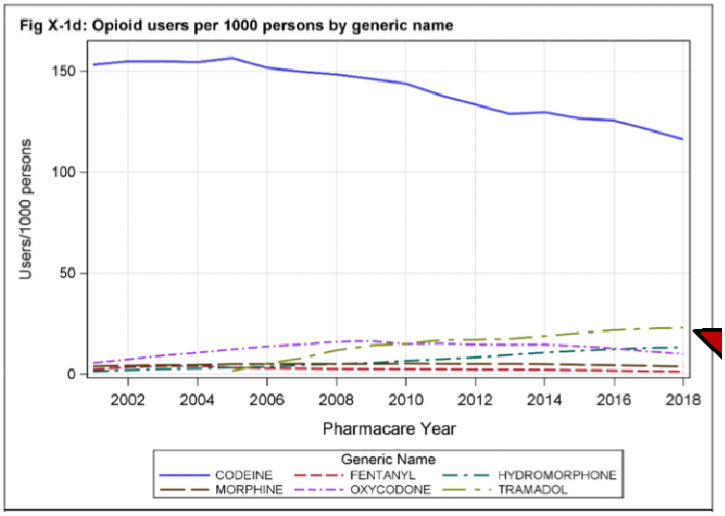
The Manitoba Prescribing Practices Program (M3P) is a provincial prescription monitoring program, specifically intended to minimize the risk for diversion of narcotic and controlled drugs. The M3P drug schedule includes narcotic and controlled drugs which are strictly regulated, with the program facilitating a monitored approach of drug utilization. In accordance with Section 76 of the Pharmaceutical Regulation, CPhM and CPSM Councils establish the M3P schedule of drugs. Therefore, approval from CPSM is also required for any changes to the M3P list.

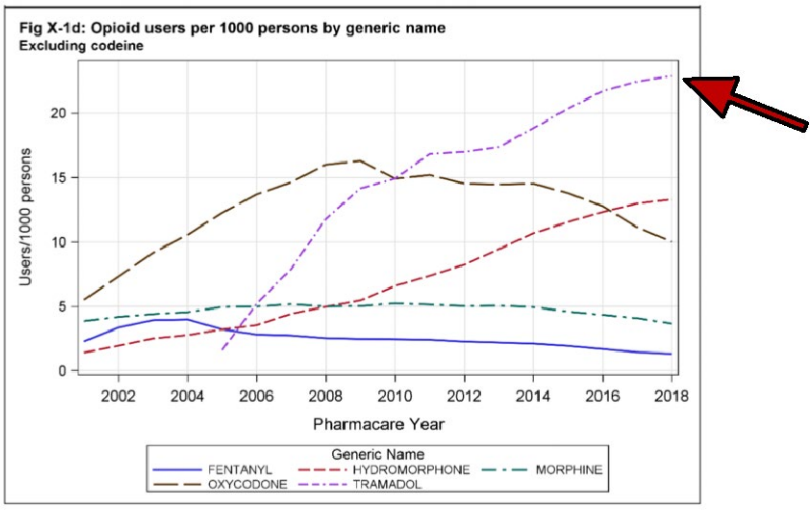
Tramadol and its salts, isomers and derivatives will be listed in Schedule I of the CDSA effective March 31, 2022. This CDSA Schedule also includes several other drugs (e.g., amphetamines, buprenorphine & naloxone, codeine, fentanyl, hydromorphone, ketamine, methadone, morphine, tapentadol, etc.), which make up the majority of drugs listed under the M3P program.

At this time, all single entity narcotics and all narcotic preparations (1 narcotic + 1 active non-narcotic ingredient), such as the tramadol products currently available on the Canadian market, are included in the M3P program under the "Narcotic Drugs" category (see Provincial Prescription Regulation Summary Chart for more information). Including tramadol products on the M3P list would fall in line with previous Council decisions and would lessen confusion in practice regarding tramadol prescription requirements.

Based on the 2020 Manitoba Prescription Opioid Atlas (an analysis of April 2001 to March 2019)* tramadol use in Manitoba has been on the rise since its introduction to the Canadian market in 2005 (information is included here with permission from the authors: Kevin Friesen, Dr. Shawn Bugden, and Dr. Jamison Falk).

The two graphs below from the 2019 Opioid Atlas visually show the number of tramadol users in Manitoba per 1,000 persons between 2001 and 2018, compared to other commonly prescribed opioids.





More recent data from the Opioid Atlas show that, although representing a small portion of opioid prescribing compared to codeine-containing products, tramadol users in Manitoba increased 17-fold from 1,473 (in 2005/2006) to 25,046 (in 2018/2019).

*(*Data for the Opioid Atlas was obtained from the Population Health Research Data Repository housed at the Manitoba Centre for Health Policy, University of Manitoba and were derived from data provided by Manitoba Health.)*

An environmental scan of other provinces was conducted to determine if tramadol is currently a monitored drug through provincial prescription monitoring programs parallel to the M3P program, and what changes, if any, are anticipated in March 2022. Results are shown in the table below:

Province	Prescription Monitoring Program	Tramadol Currently Included?	Anticipated Changes in March 2022
BC	Controlled Prescription Program (CPP) Prescriptions must be written on a duplicate, two-part form. Prescription forms personalized, numerically recorded and cannot be exchanged between prescribers.	No	Under discussion.
AB/YT	Triplicate Prescription Program (TPP) Prescriptions must be written on a three-part form. Prescription forms are personalized and cannot be shared. There are Type 1 medications which require a prescriber to register with TPP Alberta and use a TPP Alberta secure prescription forms. Type 2 Drugs are monitored electronically through Alberta Netcare, Pharmaceutical Information Network (PIN) but do not require a prescriber to register or use a TPP form.	Yes, but only as a Type 2 Drug	Alberta type 2 medications are monitored in the same manner and with the same level of diligence as type 1 drugs, but do not require the use of the secure TPP form. Type 1 medications are drugs that have shown a higher propensity for forgery. Inclusion on this list is based on data, regardless of the scheduling of the medication. As tramadol is currently being monitored, there are no plans to change the status of tramadol at this time.
SK	Prescription Review Program (PRP) No special forms required.	Yes	N/A
ON	Narcotic Monitoring System (NMS) No special forms required. NMS monitors any controlled substance under the CDSA, and other opioid medications that may not be listed under the CDSA.	Yes	N/A
NS	Nova Scotia Prescription Monitoring Program (NSPMP) Program monitors the drugs outlined in the CDSA,	No	Tramadol will be added to the list effective April 1st, 2022.

Province	Prescription Monitoring Program	Tramadol Currently Included?	Anticipated Changes in March 2022
	and includes narcotics, stimulants, and benzodiazepines. Duplicate prescription pads are required for all monitored drugs except benzodiazepines.		
NB	Prescription Monitoring Program (PRP) No special forms required. Monitors all narcotics defined under the NCR, controlled substances defined by the CDSA, opioids not listed in the CDSA (e.g., tramadol), benzodiazepine-related drugs not listed in the CDSA (e.g., zopiclone), and controlled drugs defined in the FDR.	Yes	N/A
PEI	No formal drug monitoring program released year. All drugs are entered into the provincial Drug Information system (DIS) and pharmacists expected to exercise due diligence.	No	N/A
NFL	Tamper Resistant Prescription drug pad Program (TRPP) NOT a monitoring program. No data collected. Prescription pad numbered, but no tracking done.	Yes	N/A

Recommendation

Based on the information shared above, Council may wish to consider the following motion, which will also be put forward to the CPSM Council:

> It is moved by _____ and seconded by _____ to approve the addition of all single-entity tramadol products and tramadol preparations (tramadol + 1 active non-narcotic ingredient) to the Manitoba Prescribing Practices Program (M3P) list, pending approval from the College of Physicians and surgeons of Manitoba (CPSM) Council.

Supporting documentation:

i. The Controlled Substances Bulletin: Amendments to the *Controlled Drugs and Substances Act* and the *Narcotic Control Regulation*.
ii. Provincial Prescription Regulation Summary Chart (M3P and non-M3P) https://cphm.ca/wp-content/uploads/Resource-Library/Legislation/M3P-Provincial-Prescription-Regulation-Summary-Chart.pdf

0035

DECEMBER 17, **2021**

THE CONTROLLED SUBSTANCES BULLETIN

PRODUCED BY THE OFFICE OF CONTROLLED SUBSTANCES

This bulletin provides pharmacy regulatory authorities with information and reminders relating to the upcoming scheduling amendment of tramadol and its impact on pharmacist activities.

Amendment to the Controlled Drugs and Substances Act and the Narcotic Control Regulations

The Office of Controlled Substances (OCS) would like to remind Pharmacy Regulatory Authorities (PRA) that as of **March 31, 2022**, tramadol will be removed from the Prescription Drug List (PDL) and listed in Schedule I of the *Controlled Drugs and Substances Act* (CDSA). Tramadol will also be listed as item 19 in the Schedule of the *Narcotic Control Regulations* (NCR) and therefore subject to all the regulatory requirements set out in the CDSA and NCR. Controlling tramadol will strengthen Health Canada's oversight of legitimate activities with this substance, and facilitate detection and prevention of diversion.

Record Keeping Requirements

Starting March 31, 2022, pharmacists will be responsible for maintaining, in an auditable manner, all the records required by the NCR regarding their activities with tramadol for a minimum of two years. This includes, but is not limited to the following records:

- Purchase records
- Records of receipt
- Sale/Provision records
- Emergency transfer records
- Records of returns to licensed dealers
- Destruction records

Furthermore, pharmacists must include all tramadol prescriptions dispensed on or after March 31, 2022 in their special narcotic prescription file. This includes part-fills of tramadol that may be dispensed after March 31, 2022 pursuant to a prescription received or partially filled prior to the scheduling change.

Pharmacists must perform inventory counts and reconciliations on a regular basis (at minimum, every six months, after a pharmacy move, and after a change in pharmacy manager or owner) to ensure all controlled substances (including tramadol) are accounted for. If discrepancies are discovered, they must be investigated. Unexplained losses must be reported to the Office of Controlled Substances as a loss or theft within ten days of discovery.

Destruction

Pharmacists are reminded that starting March 31, 2022, post-consumer returns or unserviceable stock containing tramadol must be destroyed according to the instructions provided in the following guidance documents:

- Guidance Document: Handling and destruction of post-consumer returns containing controlled substances
- Guidance Document for Pharmacists, Practitioners and Persons in Charge of Hospitals: Handling and Destruction of Unserviceable Stock Containing Narcotics, Controlled Drugs or Targeted Substances

Any questions relating to the destruction of post-consumer returns or unserviceable stock can be directed to compliance-conformite@hc-sc.gc.ca.

Notice of Prohibition of Sale

Effective March 31, 2022, pharmacists must not sell or provide tramadol to a pharmacist or a practitioner that is named in a notice of restriction on which narcotics are listed, except when dispensed to them as a patient. Furthermore, a pharmacist cannot dispense a prescription for tramadol signed by a practitioner who is named in a notice of restriction for narcotics.

Additionally, pharmacists named in a notice of restriction on which narcotics are listed will not be able to purchase tramadol from licensed dealers or from other pharmacists for emergency purposes.

General Obligations of a Pharmacist

Loss or Theft Reporting

Pharmacists are reminded that starting March 31, 2022, any loss or theft of tramadol or tramadol containing products must be reported to the Minister within **10 days of discovery**.

For more information regarding the submission of loss or theft reports, please refer to the guidance document:

- Reporting Loss or Theft of Controlled Substances or Precursors (CS-GD-005).

Questions regarding losses or theft may be sent to ocs.reporting-rapporter.bsc@hc-sc.gc.ca.

Security

Pharmacists shall take all reasonable steps that are necessary to protect tramadol on their premises or under their control against loss or theft.

Advertising and Labelling

Pharmacists must not advertise tramadol to the public, and must not publish a written advertisement about tramadol unless that advertisement displays the symbol “N” in a clear and conspicuous colour and size in the upper left quarter of the label and on the first page of said advertisement.

Lastly, Health Canada is allowing all units of tramadol, which were released and distributed prior to March 31, 2022, to be depleted off the market. To ensure patients receive consistent information regarding the risks and safe use of opioids during the transition period, pharmacists are reminded to affix the warning sticker and provide the patient information handout, as currently required under the *Food and Drug Regulations*.

For additional information regarding the amendment to the NCR, please visit the Canada Gazette, Part II, Volume 155, Number 7.

COUNCIL MEETING –MARCH 23, 2022

NOTICE OF MOTION FOR APPROVAL

SUBJECT: Change the word Member to Registrant

BACKGROUND:

The RHPA and Regulations use the term "Members" to describe all those registered to practice medicine at whatever stage of practice they are. This includes medical students, physician assistant students, residents, physician assistants, clinical assistants, and physicians. CPSM has been guilty of referring to all of them as physicians, which clearly many are not. This creates confusion – when using the word physician does this apply to residents? to physician assistants? to clinical assistants? It is also disrespectful to the non-physicians registered by CPSM to practice medicine in Manitoba.

In its official documents, CPSM uses the word "Member" since that is the appropriate legal term and includes all those registered by CPSM. However, the term member has certain connotations that may be seen to be problematic, including the "club-like" perception held by many in the public towards this self-governing professional regulatory body that it regulates in the interest of the profession and not the public. Membership also has negative connotations such as exclusive golf clubs, country clubs, and "old-boys clubs". Neither of these are reflective of CPSM, yet nomenclature is important.

In his report on the BC College of Dentists, Cayton noted the following:

> 3.1 The Health Professions Act (HPA) refers to the professionals who are regulated within its framework as both 'registrants' and 'members' of a college. This reflects an inherent confusion as to the nature of a college and its relationship to the people it regulates. 'Members' implies that the dentists own and control CDSBC; 'registrants' that they are registered with and controlled by the College. These two conflicting perceptions run through the way the College and its board and registrants behave and how they perceive their roles and responsibilities. A former member of staff described it thus: 'My view is that the biggest problems here, the biggest resistance here, comes from two fundamental issues. The first is the misunderstanding of the role and duties of a regulator by this registrant base. A huge misunderstanding…. You know, the lack of understanding about what the College's role is causing a lot of the issues, a lot of the disappointment and the politicking and many other things stem from this. Either a refusal to acknowledge or a… plain ignorance as what the College's role is'.

Several other Colleges in Canada use the term “Registrant” to describe all those registered to practice medicine in their province, even if their legislation refers to them as members.

It is recommended that the Bylaws, Standards of Practice, and Council policies be amended to use the word registrant rather than member unless it is a quote from the RHPA or Regulations. CPSM will change all other communications to reflect this.

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

Although it is just a name change, it is important to move away from the term members given the connotations explored above. This is particularly important for the public who appear to be excluded by virtue of non-membership. It also creates a barrier to those seeking a review of a physician’s care – the members decide about one of their own members.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 23, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> That the word “registrant” be substituted for “Member” in the CPSM Bylaws, Standards of Practice, Practice Directions, and Policies unless it is a direct quote from the legislation.

COUNCIL MEETING - MARCH 23, 2022

FOR INFORMATION

TITLE: Update of Strategic Organizational Priority - TRC Advisory Circle

BACKGROUND

The TRC Advisory Circle has met twice to date. The TRC Advisory Circle is led by Dr. Lisa Monkman. Attached is a list of the participants. By design, the Advisory Circle is larger than a Working Group to capture the many learned experiences of indigenous physicians, public representatives, knowledge keepers, and experts in racism. Each meeting has members making powerful and impactful statements about racism by the medical profession – racism against patients directly, racism against indigenous persons in general, racism against indigenous physicians, and racism against indigenous health care professionals and staff.

The TRC Advisory Circle is very respectful and offers an environment in which individuals do speak very freely, often about intensely personal and hurtful experiences and incidents of racism. Though the discussion may seem wide-ranging at times, the TRC Advisory Circle is beginning to coalesce around certain core recommendations for CPSM to implement to eradicate racism in the practice of medicine. The three Registrars, the President, and General Counsel attend the meetings of the TRC Advisory Circle and have all been touched by the stories, experiences, policies, and studies shared.

At the March TRC Advisory Circle meeting, representatives from the College of Physicians & Surgeons of Alberta will attend virtually to discuss their introduction of restorative justice techniques adopted to address anti-indigenous racism. This will be a very interesting session.

Like Council and other committees, the TRC Advisory Circle sometimes struggles with the jurisdiction of CPSM and wades into health care system issues.

Council was very direct at its Blue Sky meeting that CPSM should proceed quickly with the TRC Eradicating Anti-Indigenous Racism strategic organizational priority and re-affirmed its importance to the medical profession. Accordingly, it is intended that Council discuss this in some depth.

For the March Council meeting, Dr. Monkman has agreed to speak to Council on the TRC Advisory Circle, including its composition, preliminary discussions, and future directions. Council will also be asked to view together the film *The Unforgotten*, the Canadian Medical Association 35 minute movie that shines a light on the impacts of colonialism and systemic racism on the health and well-being of Indigenous peoples. If you have already seen this movie, you will know its impact. Dr. Monkman will also lead a discussion on this, relating it to the work of the TRC Advisory Circle.

In this movie each chapter in the five-part anthology uncovers a different experience tied to the health outcomes of Indigenous peoples living in Canada, some of which are told through first-person accounts. These include a Métis Elder who recounts the traumatic events he experienced at an Indian hospital, an artist who pays tribute to an Indigenous man who died waiting for emergency care and two First Nations Elders who share the teachings of traditional medicine from the sacred grounds of their ancestors, an Inuit youth considering suicide, and a First Nations woman who was sterilized without her consent.

Cultural safety is an important concept for reconciliation. Cultural safety expands the concept of cultural understanding to analyze power imbalances, institutional discrimination, colonization and colonial relationships as they apply to, and impact on, service delivery. Cultural safety means providing services that show respect for culture and identity, incorporate a person's needs and rights, and are free of discrimination. It requires us to examine our history, policies, and processes that create power imbalance and health and social inequities between Indigenous people and all others. Indigenous cultural safety is often seen on a continuum that includes cultural awareness, cultural sensitivity and cultural competence. (This is taken from the MICST course below)

Also, it is intended that every Councillor complete a course on Indigenous cultural awareness. This has been discussed at a high level in the past, but no action taken. With the comments from councillors at the Blue Sky Meeting, at this point it seems prudent and timely to offer this training to councillors. While the Manitoba Indigenous Cultural Safety Program (MICST or San'yas as it is also known) is Manitoba specific to healthcare, it has a lengthy waiting list and is completed over a period of eight weeks.

MICST is on-line, asynchronous and facilitated delivered over an 8-week period. Each cohort consists of 25 participants, and on average, participants take about 8-10 hours to complete the training. Components of the training include discussion boards and journal entries allowing participants to connect with facilitators and other participants. Participants can:

- Learn about the concept of culture, as well as cultural diversity among Indigenous peoples and the context and legacy of colonization.
- Gain an understanding of the health disparities of Indigenous people including social determinants of health as they relate to Indigenous people and the importance of cultural safety in reducing health disparities.
- Gain an understanding of the potential role of culture and Indigenous healing in patient care.
- Explore their own cultural assumptions, beliefs and attitudes with respect to Indigenous people.

Another alternative which is available immediately is The Path which all CPSM staff have taken over six hours of self-directed modules. All CPSM staff can attest to the high quality of this on-line training module. With videos, quizzes, music and animation, The Path is lively and engaging.

> The Path: Your Journey Through Indigenous Canada is a series of five online modules. Topics include:
>
> - the cultural and historical differences between First Nations, Inuit, and Métis;
> - the evolution of the relationship between Canada and Indigenous people from pre-contact to yesterday's headlines;
> - stories of social and economic success, reconciliation and resilience;
> - understanding intercultural communication in the workplace;
> - and much more.

There is a lengthy waiting period to get into the MICST course. The Path is immediate. The comparative costs are $280.00/seat and $120.00/seat respectively. The Path is completed on its own, whereas the MICST course is in a group with anonymous discussions by the participants led by a facilitator.

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

Eradicating anti-Indigenous racism in medical practice is central to the public interest. Similarly, prescribing practices are key to patient safety and an integral role to most CPSM registrants' practice.

Truth and Reconcilliation - Addressing Anti-Indigenous Racism by Medical Practitioners Advisory Circle

Sal	First	Last	Organization
Dr.	Lisa	Monkman	CHAIR - CPSM Member
Dr.	Lance	Crook	CPSM Member
Dr.	Courtney	Leary	Norway House Cree Nation Health Centre for Excellence Project Team
Dr.	Mandy	Buss	CPSM Member, Indigenous Health Lead, Dept of Family Medicine
Dr.	Sheila	Menard	CPSM Member
Ms	Eileen	Gelowitz	CPSM Public Representative
Dr.	Sara	Goulet	CPSM Member, Associate Dean of Admissions, UofM College of Medicine, Seniro Lead - Fly-in Program Omgomiizwin Health Services
Dr.	Nicole	Vosters	CPSM Member
Mr.	Wayne	Clark	Executive Director of Indigenous Health Initiatives, UofA, Faculty of Medicine & Dentistry
Ms	Leslie	Agger	CPSM Public Representative
Ms	Leslie	Spillett	University of Winnipeg
Ms	Debra	Beach	University of Manitoba
Ms	Valerie	Williams	University of Manitoba
Dr.	Joel	Kettner	CPSM Member, Associate Professor Dept of Community Health Sciences, College of Medicine, UofM Faculty of Health Sciences
Dr.	Christine	Polimeni	Vice-Dean, Continuing Competency and Assessment Assistant Professor, Department of Family Medicine Rady Faculty of Health Sciences
Dr.	Linda	Diffey	develops UGME curriculum at UofM
Ms	Lorraine	McLeod	FNHSSM - First Nations Health & Social Secretariat of MB
Dr.	Barry	Lavallee	CPSM Member
	CPSM STAFF		
Dr.	Anna	Ziomek	CPSM, Registrar
Dr.	Jacobi	Elliott	CPSM President
Dr.	Ainslie	Mihalchuk	CPSM, Assistant Registrar
Dr.	Karen	Bullock Pries	CPSM, Assistant Registrar
Ms	Kathy	Kalinowsky	CPSM, General Counsel
Ms	Karen	Sorenson	CPSM, Administrative Support

Meeting Dates
Tuesday, January 11, 2022
Tuesday, February 8, 2022
Tuesday, March 8, 2022
Tuesday, April 12, 2022
Tuesday, May 10, 2022
Tuesday, June 14, 2022

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –MARCH 23, 2022

FOR INFORMATION

SUBJECT: **Strategic Organizational Priorities Update**

BACKGROUND:

Prescribing Practices Review

In January the start of the Prescribing Practice Review was delayed just prior to the first meeting due to pressures on all health care providers' time relating to COVID hospitalizations. As the hospitalization rate decreases, the health care providers involved in the Prescribing Practices Review will have more time to address this matter and the initiative will be restarted.

See attached Organization Priorities Tracking Chart for information on other priorities.

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

Eradicating anti-Indigenous racism in medical practice is central to the public interest. Similarly, prescribing practices are key to patient safety and an integral role to most CPSM registrants' practice.

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

STRATEGIC ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Prescribing Practices Review		21-Sep-21		Almost Formed					Delayed	March 2, 2022 - Will be scheduling a meeting to take place by the end of March
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners		21-Sep-21		Formed					On Track	The Advisory Circle has met 3 times to date with meetings scheduled monthly until June 2022
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	22-Jul-21	On Track	Draft should be ready to go to Council in Mar 2022 for approve for consultation
Complaints Investigation Restructuring										Placeholder if this is a Strategic Organizational Priority
Streamlined Registration - Fast Track Application	FMRAC-Started								Not Started	
Streamlined Registration - Portable Licence	FMRAC-Started								Not Started	Amendments to Acts Required in many jurisdictions
Artificial Intelligence	FMRAC-Started								Not Started	

Last revised: March 2, 2022

COUNCIL MEETING – MARCH 23, 2022
FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met virtually on January 25, February 15, and March 3, 2022.

The January 25th meeting was to discuss the December Governance session report from Mr. Chisholm. The February 15th meeting was to review the electoral districts and elections coming up in 2022. As a result of this meeting a special meeting of Council was scheduled for March 10, 2022.
The March 3rd meeting was to review the March 2022 Council Agenda, and various other matters were discussed.

Members of the Executive Committee formed an Appeal Panel that met on February 15, 2022, to hear two Investigation Committee appeals.

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

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. January 31, 2022 3rd Quarter Financial Statements

- Management presented the January 31, 2022 financial statements of CPSM.
- At the end of the 3rd quarter CPSM posted an excess of revenue over expenditures of $34,000.
- This positive variance has resulted from impacts related to COVID, lower than anticipated expenses for this period as well as timing issues.

2. Human Resources planning update

- The Committee received a presentation on CPSM's human resource planning and how this is integral to the CPSM financial sustainability plan.
- Key areas were reviewed and discussed with the committee as well as potential financial impacts.

3. Information Technology Security Audit

- CPSM underwent a third-party information technology (IT) risk assessment using the Centre for Internet Security (CIS) framework
- The results of the audit were discussed with the committee including where CPSM scored high as well as areas that require mitigation.
- The committee, along with management briefly discussed future IT investments that will be required in the next 1-5 years.

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

PROGRAM REVIEW COMMITTEE REPORT:

Meeting Date: 23 February 2022

Diagnostic Facilities

The Committee discussed patient access to diagnostic imaging services and the wait time to get an appointment for services. The CPSM Collaborative Care Standards of Practice state that the Consultant member "must respond to the patient and member verbally or in writing to a request by a member for a non-urgent consultation within 30 days of receipt of the request and must notify the patient and the referring member of the anticipated appointment date."

The Committee feels that requests for imaging studies are considered consultations and should be included within the collaborative care standard, not withstanding the facility's involvement in clerical resource management decisions. A letter from the Chair of PRC to the Registrar will be sent requesting that this standard be enforced by CPSM, with notification of private facility and Shared Health medical directors, to facilitate compliance by physicians practicing within their facilities. It was noted that even if this standard were applied the patient may still not receive the requested service per se for some time.

Non-Hospital Medical Surgical Facilities (NHMSF)

An update was provided on the "reboot" of the NHMSF program to comply with the revised CPSM bylaw. A new Adverse Patient Outcome (APO) Consultant Review form has been introduced for the Consultants to provide their feedback and recommendations for the Committee. The form has been very well received by the Consultants. We are starting to clean up the backlog of APOs that have been reported and expect that the majority should be reviewed by Consultants for the next PRC Meeting.

The work continues around the implementation of new NHMSF operational standards. Many NHMSF subject matter experts have been engaged to ensure that these standards are comprehensive but also to help identify areas that may require additional attention as the Non-Hospital Medical Surgical Facilities work to comply with the new standards.

This work is in its final stage and it is the hope that roll out can occur in April and accreditation inspections can begin.

Respectfully submitted
Dr. Wayne Manishen
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

Complaints Received between
01-May-2021 and 25-Feb-2022

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Complaint Received	Total Cases
May/2021	11
June/2021	5
July/2021	6
August/2021	23
September/2021	22
October/2021	26
November/2021	26
December/2021	27
January/2022	15
February/2022	3
Grand Total	164

Committee Reports

Length of time required to acknowledge complaints received between 01-May-2021 and 25-Feb-2022

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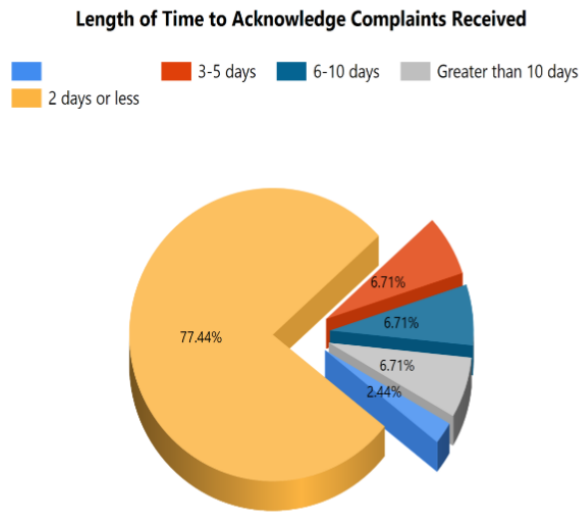
Complaints Acknowledge In	Total Cases
	4
2 days or less	127
3-5 days	11
6-10 days	11
Greater than 10 days	11
Total number of complaints cases in time period:	164



Length of time required to resolve complaints for cases closed between 01-May-2021 and 25-Feb-2022

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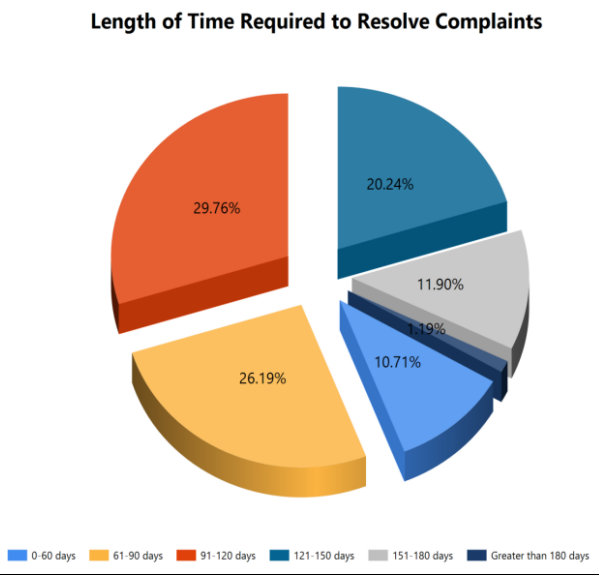
Complaints Cases with	Total
0-60 days	9
61-90 days	22
91-120 days	25
121-150 days	17
151-180 days	10
Greater than 180 days	1
	84



We are all settling into the new routine and we welcome Dr. Dixon and Dr. Stephenson to their roles as Medical Consultants.

Respectfully submitted
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

IC meetings since our last Council meeting include:

1) December 15, 2021 -> 9 cases reviewed.
2) January 12, 2022 -> 2 cases reviewed.
3) February 18, 2022 -> 8 matters reviewed re one physician.
4) Two censures were administered on February 3 by the Chair over Zoom with CPSM legal counsel support.

Decisions

From our last three meetings the breakdown of our decisions are as follows:

No Further Action = 5
Letter of Criticism = 4
Letter of Advice = 1
Defer pending further information = 8 (all from the February meeting)
Censure = 1

As of today, there are 126 outstanding investigation cases.

Our department has gained a full-time administrative assistant and a part time Medical Consultant (3 days per week).

Please let me know if there are any questions.

Respectfully submitted
Dr. Kevin Convery
Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

Central Standards Committee (CSC) Activities

The CSC met December 17, 2021, and February 4, 2022.

AGE TRIGGERED/REFERRED AUDITS 2021 and 2022

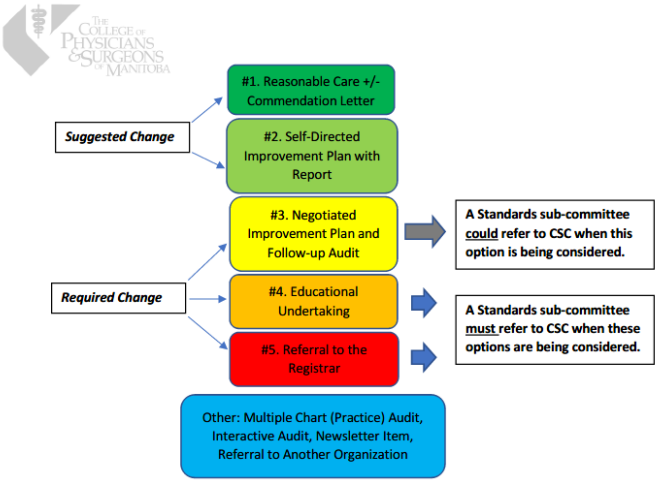
The CSC reviewed:

10 age triggered audits and 7 referred audits at the December 17, 2021, meeting.

2 age triggered audits and 6 referred audits at the February 4, 2022, meeting.

The following were the outcomes determined from those meetings.

7	#1 outcomes
10	#2 Outcomes
4	#3 outcomes
3	#4 outcomes
1	#5 outcomes
1	Other – Interactive Audit
26	Total (2 outcomes from a referred audit)



Standards Sub-Committee Reporting.

The Central Standards Committee has begun receiving quarterly reports from the various Area Standards Committees within the province. To date the CSC has reviewed reports from:

Child Health Standards Committee Quarterly 3 and 4 Reports
Child Health Standards Committee Year End Report
C.W. Wiebe Quarterly Report
Brandon Regional Health Committee Psychiatry Quarterly Report
Eden Mental Health Centre Quarterly Report
Prairie Mountain Health South Area Quarterly Report
Portage Area Standards Committee Quarterly Report

Respectfully submitted
Dr. Roger Suss
Chair, Central Standards Committee

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING –MARCH 23, 2022

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

COVID-19 Pandemic

Since the December meeting of Council, the milder Omicron variant arrived in Manitoba, infected an unknown yet massive segment of the population, created a surge in hospitals, causing the need for level loading of patients to health regions outside of Winnipeg.

CPSM responded just before Christmas by issuing a notice to the profession relaxing the Standard of Practice for Virtual Medicine thereby allowing a full re-introduction of virtual medicine to many practices as the overall population was told to stay home yet again.

At the end of February, CPSM issued a new FAQ on virtual medicine:

> CPSM members are **required to resume in-person care**. Virtual medicine can complement in-person care delivered to each patient. Review the Standard to ensure you are providing a blended model of care balancing in-person care with any virtual medicine provided. If you provide virtual medicine, you must have the ability to see a patient in-person in a timely manner when required or requested. The Standard's intent is:
>
> 1. **In-person care should be the routine medical care provided**. Virtual medicine should be used to complement your in-person practice.
> 2. Timely in-person care is required when clinically necessary or if it is requested by the patient.
> 3. It is not an acceptable standard of care to only practice virtual medicine.
> 4. Practicing virtual medicine through online telemedicine companies does not likely meet the Standard of Practice requirements. Virtual Medicine through online telemedicine companies can only meet the requirements for good care if each CPSM member can provide timely in-person care – usually within 24 hours for family medicine/primary care – to a patient that is in their immediate geographic vicinity. This includes psychotherapy.

During this fourth Omicron wave, the care provided by many CPSM registrants (and other health care professionals) was once again truly heroic with incredibly long hours, difficulty in finding beds, and other challenges by a health care system that has been further battered by transformation and two years of this pandemic. Others had their surgeries and procedures they were scheduled to perform cancelled as the health care system once again struggled with increased numbers of COVID-19 patients.

The President and Registrar issued this message to members at the height of the fourth wave. https://cpsm.mb.ca/assets/COVID19/Message%20from%20the%20President%20and%20Registrar%2001%2019%2022.pdf

In mid-February the Province surprised many by announcing the Public Health Orders for providing proof of vaccination and for Mask requirements would end on March 1 and 15 respectively. Accordingly, there will be no legal requirement for any patient to wear a mask if they decline to do so. CPSM responded with the following FAQ to the registrants.

WHAT DOES THIS MEAN FOR YOUR PRACTICE IN A NON-INSTITUTIONAL SETTING?
With the Public Health Orders changing, the demands on the healthcare system are not entirely over. CPSM encourages you to continue using the safety protocols you have come to rely on to protect yourselves, your patients, and your staff. However, the safety protocols must not restrict the access to care or the quality of care you provide.

Screening
Continue screening protocols in your practice to accurately plan for in-person care. Screening must not restrict patients from receiving in-person care.
E.g. A patient with a cough or sore throat must not be turned away.

Patients must not be required to produce proof of a negative COVID-19 test to access in-person care.

Have a contingency plan for seeing patients in person with possible COVID-19 symptoms. Some practices set aside a window of time at the beginning or end of a day to see such patients. Patients who are either unvaccinated, have COVID-19, or with possible COVID-19 symptoms must not be denied in-person medical care.

Masks & PPE
Public Health recommends all persons continue to wear masks. You can ask and recommend staff and patients to continue wearing masks after the provincial requirements are lifted on March 15; however, you cannot deny in-person care to patients for not wearing masks after the restriction is lifted.

If You Practice in an Institutional Setting
If you practise in an institutional setting, follow PPE guidance per Shared Health or institutional policy, which may vary depending on your practice and the clinical encounter.

CPSM received feedback and pushback from a number of registrants who expressed dismay with this approach.

CPSM staff also dealt with numerous inquiries from anti-vaxxers, and from registrants who often struggled with such positions and patients.

Fair Practices in Regulated Professions Amendment Act

The Fair Registration Practices in the *Regulated Professions Amendment Act* has been proclaimed. It is an attempt to further reduce barriers for internationally educated professionals to register in Manitoba's self-regulated professions, including medicine.

Amendments to the *Fair Registration Practices in Regulated Professions Act* transitions the Office of the Manitoba Fairness Commissioner to a new Fair Registration Practices Office within a Government Department. The amendments also include:

- proactively ensuring professions comply with domestic trade agreements such as the Canada Free Trade Agreement and the New West Partnership;
- clarifying the requirement for professions to ensure registration requirements and assessments for internationally educated applicants are necessary;
- obligating self-regulatory bodies to notify the office of changes to their assessment and registration practices;
- allowing the establishment of a timeliness standard for registration of qualified internationally educated applicants by regulation; and
- authorizing the minister to issue compliance orders when necessary, through enforcement mechanisms outlined in the legislation.

CPSM met with the Fairness Commissioner Office in the past and will continue to meet with the Fair Registration Practices Office. The issues raised in the Act are already in the process of being implemented.

Registrants' Numbers on Practitioner's Profile

Health Canada has as a requirement on cannabis authorizations that the prescriber include their registration number and that the cannabis dispenser must check to ensure that the registration number is correct, and the prescriber is indeed registered. This is actually included in the regulations. Several cannabis dispensers contacted CPSM to inquire about the registration numbers. Other stakeholders occasionally inquire about the registration number of a registrant for a variety of reasons.

CPSM is unique in that it does not include the registration numbers on the practitioners' profile. The provinces of Ontario, Alberta, BC, and Nova Scotia include the registration number on the physician profile. Saskatchewan does not. Those including the registration numbers have not noticed any problems with this public listing of registration numbers. CPSM is now including the registration number on the practitioners' profile on CPSM's website.

This was communicated to members in the February 2022 newsletter that was sent out on February 28, 2022.

STAFF MATTERS

With the Complaints and Investigations department settling into the second floor, CPSM has been busy reconfiguring space on the 10th floor. The reconfiguration will allow for improved teamwork within the departments as well as allow flexibility in accommodating auditors and special projects.

MEETING WITH GOVERNMENT OFFICIALS

Public Health Orders Meetings
CPSM continued to attend biweekly meetings with the Chief Medical Officers of the Health Regions, Public Health leaders, Program Leads and Shared Health up until the end of January. As of February 1st these meetings were discontinued due to the change in Public Health orders to Public Health recommendations.

Chief Medical Officers Meetings
I attend monthly meetings with the Chief Medical Officers of the regional health authorities. Matters discussed are wide ranging and include health care resources and constraints, workforce planning, COVID, ongoing and new health care transformation initiatives from the government.

Manitoba Clinical Leadership Council
I continue to attend their monthly meetings.

MEDIA

Earned Media
Following the approval of the Standard of Practice for Office-Based Procedures at the December Council meeting, a media release was shared with media outlets on December 15 to announce the Standard would be effective January 31, 2022. The goal was to bring attention to the intention of the standard and to demonstrate transparency to the public, which was necessary due to the number of responses received from the consultation. The Winnipeg Free Press covered the announcement. The Medical Post also interviewed Dr. Mihalchuk on the Standard for their next publication.

Media Requests
CPSM was contacted by media ten times between January 1 and March 4. CPSM provided comments on psychiatry and mental health wait times (Brandon Sun), a physician who donated to the convoy (Winnipeg Free Press) and provided information and comment on the directives CPSM registrants were provided regarding mask exemptions (Winnipeg Free Press).

Communications
The news section on the website has been updated and changes to the format of the CPSM newsletter from PDF to a monthly digest.

A webinar on the Complaints and Investigation process for CPSM registrants was held on January 26. Over 400 registered. Positive comments were received and the questions submitted were turned into a Q&A document to accompany the new Practice Direction.

FINANCE

Nothing to report that is not included in the Finance, Audit & Risk Management Committee Report section of the agenda.

INFORMATION TECHNOLOGY

1. Launched a new Complaints Form in the CPSM Portal. The public can file complaints electronically from the CPSM website.
2. Updated the Practitioner Profile Search. The new search also generates out of the CPSM Portal.
3. Transitioned to SharePoint as our electronic document management system. This was a big step toward our goal of maintaining a paperless work environment.

QUALITY DEPARTMENT

Physician Health Program

- To date this fiscal year, we have 63 new referrals to the program
- Other than the "other" category (49%), the top 2 referral categories are anxiety/depression at 17% and 11% of referrals are burnout/stress related
    - The "other" category consists of COVID, sick child, acute injury, impairment due to pain meds, etc.
- The highest method of referral is by the Registration department at 38% followed by self-referrals at 25%
- Ongoing heightened activity with members with undertakings related to anxiety/depression and substance use disorder
- Male vs. female total referrals remain consistent this fiscal year with 54% male and 46% female (last fiscal 55% male and 45% female)
- Quarterly meetings are now held between the PHP and Doctors Manitoba. This relationship continues to grow and both organizations support and encourage our members to connect with the other if needed.
    - The new IME process between Doctors Manitoba and the CPSM is working very well; members who need an IME are being assessed well before the 6-week mark and Doctors Manitoba has been covering all related costs

MANQAP

- Accreditation inspections of diagnostic facilities continue as COVID-19 pandemic restrictions are relaxed and/or removed. There will be 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 reports to CPSM. Work on adapting and implementing new operational standards to ensure that accreditation inspections are congruent with the revised Accredited Facilities Bylaw is near completion. Onsite accreditation inspection will begin this spring.

Quality Improvement

- Program operations continue – back up to full pace
- Auditor Training Workshop took place late January 2022. Another one is planned for May 2022. Attendees will be accepted based on CPSM needs/gaps – across all audit programs
- Continued expansion into different specialty areas year by year – 2022 will include Plastic Surgery, Cardiology, Radiology
- Central Standards Committee now oversees the QI Program – process going smoothly

Audits and Monitoring

- Age triggered audits will be moving onto age 73- and 72-year-old physicians for 2022.
- The total qualifying audits to be scheduled is 69.
- This includes
  - 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
  - 8 referred audits

Prescribing Practices Program

Prescribing Practices Program update for the period Dec 8th, 2021 – Present:

- SUAP Grant
  - 1 Opioid Agonist Therapy (OAT) workshop held (January 2022).
  - Suboxone Recommended Practice Manual work continues - new chapters posted as created (1 new Chapter since Dec).
  - PPP responded to 25 OAT Mentoring requests from external professionals seeking advice/support.
  - Three routine OAT audits scheduled for March 2022. Planning for 3 routine OAT audits on a monthly basis in 2022.

- Pain and Palliative Care
  -1 Methadone (for Palliative Care) prescribing approval application reviewed
  -PPP responded to 1 Palliative Care Mentoring request from a member seeking support.

- 2 Registrar Referrals processed (1 closed without action after discussion with AM, another member has asked for an extension for his initial response).

- 13 Cases reviewed, and general or case specific prescribing advice provided to external callers seeking support.

- CME Death Review Program: Review of backlog of cases has been completed from Sept to Dec 2020: 103 letters sent from Dec 8, 2021, to present. Specifically, 23 letters were FYI only (no prescribing concerns), 17 letters offered quality improvement recommendations (no prescribing concerns), 53 letters identified prescribing concerns and offered quality improvement recommendations, and 12 letters required a response due to the significant prescribing concerns that were identified. In addition, two cases were referred to CI due to active (ongoing) CI involvement.

- 5 Methadone & Suboxone (OAT) prescribing approvals reviewed & issued (29 new approvals total thus far in 2021/2022). There are 17 applications pending.

- OAT for-cause audits: 2 Members referred to CI due to unsatisfactory repeat audits after remediation attempt.

- PPP presented to Senior Leadership re information gathered from expert meeting conducted to revise Practice Direction for Pain & Palliative Methadone Prescribing approvals & training. This presentation also included Information from cross-Canada scan conducted re regulatory approaches elsewhere in Canada re this area of practice. Based on discussion, PPP created several draft versions of possible revisions to current Practice Direction for Pain & Palliative Methadone Prescribing approvals & training.

- Ketamine: Other Colleges in Canada have shared concerns regarding Ketamine prescribing by physicians, including IV Ketamine. PPP is reviewing local DPIN data to determine if similar concerns exist in MB, potentially requiring regulatory intervention.

- PPP contributed 1 article to February Newsletter.

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The Department is immersed in the new processes for resolving complaints, as presented at the December Council meeting. That is, any complaint received will be addressed either by facilitated communication, or through referral to the Complaints or Investigation Committee depending on the nature of the concerns. Complaints meeting certain criteria can be dismissed.

Dr. Bullock Pries presented information about the process and new Practice Direction to members at a webinar on January 26. The webinar was well attended and received positive feedback. Questions and answers from the webinar were posted to the website.

There has been a substantial increase in the number of complaints received in the past fiscal year. More detailed information will be available in the annual report.

Two new Medical Consultants began work in the department - Dr. Nancy Dixon joined in January (0.8EFT) and Dr. Michael Stephensen began in mid February (0.6EFT). We also added an administrative assistant to the lawyers in the department (Ms Sara Good).

The Complaints and Investigation Department is working in new offices on the 2nd floor and appreciating the physical space and available resources.

REGISTRATION DEPARTMENT

Registration Stats for the last 6 months - September 2021 to February 2022.

Registration Category	Applications Received	Applications Processed	Applications Pending
Clinical Assistants	26	9	17
Visiting Students	26	17	9
Full Practicing	34	27	7
Physician Assistants	12	10	2
Provisional Registration	59	13	46
Post Certification Trainees	12	2	10
Totals	169	78	91

One registrant successfully completed the Manitoba Practice Assessment Program in forensic pathology.

Three registrants, one in each, Internal Medicine, Diagnostic Radiology, and Infectious Diseases successfully complete the Practice Ready Assessment – Specialty Practice program.

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EVALUATION OF COUNCIL

The CPSM is interested in your feedback regarding your experience at the Council meeting. The results of this evaluation will be used to improve the experience of members and to inform the planning of future meetings.

	Strongly Disagree	Neutral	Strongly Agree	Comments
How well has Council done its job?				
1. The meeting agenda topics were appropriate and aligned with the mandate of the College and Council.	1	2	3	
2. I was satisfied with what Council accomplished during today's meeting.	1	2	3	
3. Council has fulfilled its mandate to serve and protect the public interest	1	2	3	
4. The background materials provided me with adequate information to prepare for the meeting and contribute to the discussions.	1	2	3	
How well has Council conducted itself?				
5. When I speak, I feel listened to and my comments are valued.	1	2	3	
6. Members treated each other with respect and courtesy.	1	2	3	
7. Members came to the meeting prepared to contribute to the discussions.	1	2	3	
8. We were proactive.	1	2	3	

Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate decision-making and the decision was clear.	1	2	3	
Feedback to CEO/Staff				
12. Council has provided appropriate and adequate feedback and information to the CEO	1	2	3	
My performance as an individual Councillor				
13. I read the minutes, reports and other materials in advance so that I am able to actively participate in discussion and decision-	1	2	3	
14. When I have a different opinion than the majority, I raise it.	1	2	3	
15. I support Council's decisions once they are made even if I do not agree with them.	1	2	3	
Other				
16. Things that I think Council should start doing during meetings:				
17. Things that I think Council should stop doing during meetings:				