March 22, 2023 Council Meeting

Wednesday, March 22, 2023 | 8:00 a.m. |

AGENDA

CPSM Office – Brown Room
1000 – 1661 Portage Avenue

Time		Item		Action		Page #
5 min	8:00 am	1.	Opening Remarks			
0 min	8:05 am	2.	Agenda – Approval			
0 min	8:05 am	3.	Call for Conflict of Interest			
5 min	8:05 am	4.	Consent Agenda i. Council Meeting Minutes December 14, 2022	For Approval	Dr. Elliott	4
60 min	8:10 am	5.	Performance Metrics - Quality Department	For Information	Dr. Mihalchuk	9
45 min	9:10 am	6.	Quality Prescribing Rules	For Information	Dr. Shenouda / Ms Kalinowsky	47
20 min	9:55 am	7.	--Break--			
45 min	10:15 am	8.	Physician Health Program Presentation	For Information	Dr. Mihalchuk	70
20 min	11:00 am	9.	Registration Policies • MPAP Policy • Assessment Candidate (Re-Entry to Practice) Class Policy • Practice Direction Professional Practice and Inactivity	For Approval	Dr. Ziomek / Mr. de Jong	87
15 min	11:20 am	10.	Standard of Practice Social Media	For Information	Ms Kalinowsky	124
5 min	11:35 am	11.	Strategic Organizational Priorities	For Information	Dr. Elliott/ Dr. Ziomek	149
15 min	11:40 am	12.	Standard of Practice Collaborative Care	For Approval	Dr. Elliott	152

Time		Item		Action		Page #
15 min	11:55 am	13.	Committee Report (written, questions taken) Executive Committee Finance, Audit & Risk Management Committee Complaints Committee Investigations Committee Program Review Committee Central Standards Committee	For Information	Dr. Elliott	159
10 min	12:10 pm	14.	Registrar's Report	For Information	Dr. Ziomek	164
15 min	12:20 pm 12:35 pm	15.	In Camera – With Registrar In Camera – Council only Review of Self-Evaluation of Governance Process		Dr. Elliott	
4 Hours 35 min			Estimate time			

Regulated Health Professions Act

Duty to serve the public interest

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

CPSM Mandate

10(2) A college has the following mandate:

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

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

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

COUNCIL MEETING –MARCH 22, 2023
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Consent Agenda**

BACKGROUND:

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

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

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

The following item is on this consent agenda for approval. See attached for details.

i. Council Meeting Minutes – December 14, 2022

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 22, 2023, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

The item on the consent agenda is approved as presented.

1000 – 1661 Portage Avenue, Winnipeg Manitoba R3J 3
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Website: www.cpsm.mb.ca

MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on December 14, 2022 at the CPSM offices with a number of members attending virtually.

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-Virtually
Ms Dorothy Albrecht, Public Councillor-Virtually
Mr. Chris Barnes, Associate Member
Dr. Kevin Convery, Morden-Virtually
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor
Ms Lynette Magnus, Public Councillor
Dr. Norman McLean, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Lisa Monkman, Scanterbury
Dr. Peter Nickerson, Winnipeg-Virtually
Dr. Charles Penner, Brandon
Ms Leanne Penny, Public Councillor
Dr. Ira Ripstein, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Heather Smith, Winnipeg
Dr. Roger Süss, Winnipeg

MEMBERS:

STAFF:
Dr. Anna Ziomek, Registrar
Dr. Ainslie Mihalchuk, Assistant Registrar
Dr. Karen Bullock Pries, Assistant Registrar
Ms Kathy Kalinowsky, General Counsel
Mr. Paul Penner, Chief Operating Officer
Ms Karen Sorenson, Executive Assistant
Dr. Marina Reinecke – Item #5&8
Mr. Michael Wiebe – Item #5

GUEST:
Ms Katrina Clarke

REGRETS:
Dr. Carrie Corbett, Winnipeg

2. ADOPTION OF AGENDA

IT WAS MOVED BY MS LEANNE PENNY, SECONDED BY MR. ALLAN FINEBLIT:
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. Dr. Elliott called for any requests for an in-camera session. There being a request for an in-camera session, all staff left the meeting and returned shortly.

4. CONSENT AGENDA

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. IRA RIPSTEIN:
CARRIED

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

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

5. PRESCRIBING RULES

This strategic organizational priority will be renamed the Quality Prescribing Review. Council provided informal direction on the following items which are under consideration by several regulatory bodies in Manitoba:

- Verbal prescription of controlled substances, including M3P drugs - support
- Elimination of M3P paper pads - support
- Email transmission of prescriptions – support if technically feasible
- Electronic transmission of M3P drugs introduced during COVID will become permanent - support
- Pharmacists may transfer prescriptions to other pharmacies, in and out of province – support.

The inclusion of codeine in M3P is also to be considered. The Working Group will continue its review of quality prescribing.

6. STANDARD OF PRACTICE SOCIAL MEDIA

The need for a Standard of Practice on Social Media is apparent.

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

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

7. PRACTICE DIRECTION PRESCRIBING METHADONE OR BUPRENORPHINE/NALOXONE

Due to the ongoing opioid crisis, Suboxone's superior safety profile, and no Suboxone overdose deaths in Manitoba, the requirement to demonstrate proof of education and clinical preceptorship was eliminated which will increase emergency and other necessary prescribing to improve patient safety.

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

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

8. CPSM RISK MANAGEMENT POLICY

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

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

9. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

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

10. PRESIDENT-ELECT APPOINTMENT

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

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

11. CEO/REGISTRAR'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at CPSM. Dr. Ziomek spoke verbally to this report and answered the questions presented by the Councillors. Matters included Medical Assistance in Dying for mental illness, registration matters for International Medical Graduates, and self-regulation changes in BC.

12. COMMITTEE REPORTS

The following Reports were presented to Council for information:

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

13. IN CAMERA SESSION

An in-camera session was held, and the President advised that nothing be recorded in the minutes.

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

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Dr. J. Elliott, President

_____

Dr. A. Ziomek, Registrar

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 22, 2023
BRIEFING NOTE

TITLE: Performance Metrics – CPSM Quality Department

RECOMMENDATION:

Council receives the Briefing Note for discussion.

KEY MESSAGES:

Developing Key Performance Metrics is a Strategic Organizational Priority. They enable CPSM to focus on strategic and operational improvement, creating an analytical basis for decision making and help focus attention on what matters most.

The Quality Department has developed a first approach to performance metrics (outcome and process measures) for its 5 program areas. Other departments will follow shortly.

SUMMARY:

Physician Health Program Outcome and Process Measures:

1. Outcome: Number of referrals coming from registrants about self/colleagues to the PHP.
2. Process: Time to respond with initial contact to urgent referrals (high likelihood there is a relevant health issue which may be causing impairment but does not include emergent cases where there is an immediate risk to patient safety).

Quality Improvement Program Outcome and Process Measures:

1. Outcome: CPSM will complete reviews of 95% all applicable registrants by the end of the first seven-year cycle (December 31, 2025).
2. Process: Following a category assignment for a given cohort,
    a. QI processes will be completed within 30 days for Category 1 participants (60%).
    b. QI processes will be completed within 90 days for Category 2 participants (35%).
    c. QI processes will be completed within 240 days for Category 3 participants (5%).

Audit and Monitoring (Quality Assurance/Standards) Outcome and Process Measures:

1. Outcome: "Required Change" #3 and #4 outcomes from the Central Standards Committee review of a registrant's audit result in a measurable improvement on follow-up assessment.
2. Process: The audit process from the date of the audit to addition to the next CSC (Central Standards Committee) agenda will be completed within 30 days.

Prescribing Practices Program (PPP) Outcome and Process Measures:

1. Outcome: PPP will respond to 60% of general prescribing advice inquiries within one business day and 90% within two business days.
2. Process: Medical Examiner cases with serious prescribing concerns identified are completed within 90 business days (PPP intervention completed and case closed).

Manitoba Quality Assurance Program (MANQAP) Outcome and Process Measures:

1. Outcome: MANQAP will be compliant with the deliverables of the Manitoba Health contract and inspect for accreditation purposes, the required number of laboratory and diagnostic facilities in 2023-2024. MANQAP will ensure all required NHMS facilities are inspected for accreditation purposes in alignment with the CPSM By-Law for Accredited Facilities.
2. Process: Non-emergent APOs will be reviewed by an expert (providing an opinion and recommendation about safety) and the briefing for Program Review Committee will be completed within 14 days of receipt of the complete APO file.

QUESTIONS FOR COUNCIL DISCUSSION:

1. How do these measurements help CPSM focus on strategic and operational improvement?
2. How do these measurements help CPSM better serve and protect the public interest?
3. How and when will the measurements be reported to Council?
4. When will other CPSM measurements be presented to Council?

Quality Department Performance Metrics

The Quality Department is responsible for overseeing Quality Assurance, Quality Improvement and Accreditation functions for CPSM. Our work involves ensuring the continued competence of the medical profession through a variety of proactive and for-cause interventions aimed at providing feedback and fostering learning and positive change in the interest of patient safety. We also ensure compliance with quality-of-care standards at all laboratories, diagnostic and Non-Hospital Medical Surgical Facilities (NHMSF) in Manitoba.

The Quality Department has embraced the opportunity to become a performance-driven organization and each program's staff has been tasked between October and February to reflect on the purpose of their program, how it meets our statutory and regulatory requirements and how best to utilize data to monitor performance and drive continuous quality improvement in our operations. Quality Programs include:

- Physician Health Program
- Quality Improvement Program
- Audits, Standards and Monitoring (Quality Assurance)
- Prescribing Practices Program
- Manitoba Quality Assurance Program & Non-Hospital Medical Surgical Facility Accreditation

With support and direction from the Assistant Registrar (Quality), staff in each program have identified two metrics that they feel best reflect their work for the purposes of reporting to Council for governance oversight. This exercise has provided an opportunity to expand the staff's perspective to see their routine work in new ways, connect to the purpose and impact of the work they do, and challenge them to learn and adapt to a higher level of operational expectation from leadership. It has provided positive engagement for staff and allowed them to demonstrate individual and team strengths.

We have focused on a process and an outcome measure for each program so that we can examine how we can do our work more efficiently (process) and effectively (outcome).

Descriptions of the planned performance metrics for 2023-2024 for each of the program areas for the Quality Department are provided on the following pages. As Councillors, please reflect on whether these metrics will help you monitor key aspects of operations in the Quality Department from the governance level.

It is important to note that the metrics presented here are not intended to be static over time. The goal is to start measuring what seems important (using data and tools we already have available), reflect on what information that data provides, and use it to make changes and improve where possible. This process is intended to be iterative in nature and will adjust accordingly in future years to best highlight areas of interest, concern, or new initiatives.

Performance Metrics: Physician Health Program

Purpose: To facilitate effective self-regulation through registrant disclosure of reportable health conditions, providing support and oversight to registrants with acute or chronic health concerns of a serious nature and protecting the public by ensuring identified registrants are fit to practice medicine.

Key impacts on Patient Safety:

1) Appropriate and consistent health reporting from registrants about themselves and colleagues is key to effective self-regulation and therein, protecting the public. The Standard of Practice - Duty to Report (new in 2021) has clarified the expectation for registrants to report themselves or their colleagues where there is a health concern which may cause impairment in the ability to practice medicine safely. Physicians have historically been reluctant to come forward and report. The number of individuals referred to PHP (Physician Health Program) has increased over the last 2 years.
    - 2022-2023 – 41% (out of 77 referrals to date May 1 – Feb 6)
    - 2021-2022 - 31% (out of 86 referrals)
    - 2020-2021 - 27% (out of 58 referrals)

    Increased self-reporting is likely related to increased awareness of the new standard, word of mouth from registrants who have engaged with the PHP and had a positive experience, and CPSM's efforts to build relationships with Doctors Manitoba and to capitalize on opportunities to engage with various physician groups. More registrants reporting health issues (self/colleague) reflects more effective self-regulation. It also suggests the PHP is being recognized as a safe and trusted resource within the profession to support health and well-being and engage registrants with CPSM in the context of quality. Supporting the health of registrants is of the ways CPSM can ensure quality of care for patients.

2023-2024 PERFORMANCE METRIC:

OUTCOME MEASURE: Number of referrals coming from registrants about self/colleagues to the PHP.

Current State: ~41% of referrals are from registrants about self/colleagues.

Target: Increase referrals from registrants by ~10% to ~ 50% or 1 in 2 in 2023/2024.

Rationale: Proposing a modest increase given the difficulty in changing registrant beliefs and behaviours around reporting to CPSM.

2) Timely responses and interventions are critical to the success of the PHP and achieving the goal of protecting the public in cases where a registrant is identified as practicing medicine with impairment or risk of impairment from a health condition. Quick responses mean interventions, where needed or appropriate, can be put in place sooner; this has an impact on patient safety.

2023-2024 PERFORMANCE METRIC:

PROCESS MEASURE: Time to respond with initial contact to urgent referrals (high likelihood there is a relevant health issue which may be causing impairment but does not include emergent cases where there is an immediate risk to patient safety).

Current State: Not measured.

Target: For urgent health concerns, contact is initiated with the registrant on the same business day the referral is received, 90% of the time.

Rationale: Timely response to new referrals of an urgent nature supports CPSM and PHP's mandate to protect the public. Nine out of 10 times allows for the fact that there will always be circumstances where the registrant may not be able to respond, or PHP is dealing with a different urgent matter and cannot get to a new referral the same day. Historically, minimal metrics were kept in Physician Health. In the last year, we have proactively been building and enhancing database capabilities in anticipation of the goal of using data to guide performance. The capability to track and report on these timelines is now in place.

Performance Metrics: Quality Improvement Program

Purpose: The Quality Improvement Program is a legislated activity designed to support CPSM in supervising the practice of medicine. It requires participation from all registrants once per seven-year cycle to reflect upon and identify focused ways to improve one's practice in the interest of patient safety.

Key impacts on Patient Safety:

1) CPSM has a duty to supervise the practice of medicine and ensure the competence of its registrants in the interest of patient safety. Given this is a legislated requirement, CPSM must complete the process in the required period.

2023-2024 PERFORMANCE METRIC:

OUTCOME MEASURE: CPSM will complete reviews of 95% of all applicable registrants by the end of the first seven-year cycle (December 31, 2025).

Current State: To date, after four years, approximately 42% of applicable or eligible registrants (1056/2529) have completed the program.

Target: To complete 19% of applicable or eligible registrants per annum for the remaining three years in the first seven-year cycle of the Quality Improvement Program.

Rationale: Completing this legislated activity of supervising the practice of medicine is critical to CPSM's self-regulatory duty. This metric is intended to demonstrate the program's achievement in staying on track with projected volumes per annum. Each year, there are various valid reasons participants need to defer their participation. It is conceivable that despite the program's best efforts, a small percentage of registrants will be incomplete by the end of December 31, 2025. However, this is expected to be <5% of the total cohort (125 registrants).

2) Efficient completion of the Quality Improvement Program benefits public safety through the supervision of the practice of medicine and registrant engagement/satisfaction in the process of reflection and learning. Most registrants express some degree of distress having to engage with a CPSM activity, even if it is under the Department of Quality, therefore timely and predictable processes can reduce stress. CPSM Council has identified that registrant engagement is important to regulatory success.

2023-2024 PERFORMANCE METRIC:

PROCESS MEASURE: Following a category assignment for a given cohort,

- QI processes will be completed within 30 days for Category 1 participants (60%).
- QI processes will be completed within 90 days for Category 2 participants (35%).
- QI processes will be completed within 240 days for Category 3 participants (5%).

Current State: Not measured.

Target: Each category will be completed within the identified timelines 90% of the time.

Rationale: Category 1 process completion is dependent only on CPSM staff and therefore the completion time is much shorter than Category 2 or 3. Category 2 requires an audit which adds considerable time. Category 3 requires the MCC 360 followed by an interactive audit. This adds considerable length to the process. Currently, Category 3 interactive audit and MCC 360 processes happen in series and not in parallel and the MCC process is external to CPSM; we do not have influence over those timelines. The interactive audit requires the coordination of the schedules for two auditors and the participant, which can be challenging.

The opportunity to track timelines and efficiencies enables the QI program staff to assess and implement internal quality improvements and to communicate clearly with registrants

regarding timelines for completion. There is always the potential for issues to arise in the process, with delays on the registrant or the CPSM side. 9 out of 10 times to reach the desired timelines for the process has been identified as achievable by Quality Improvement Program staff.

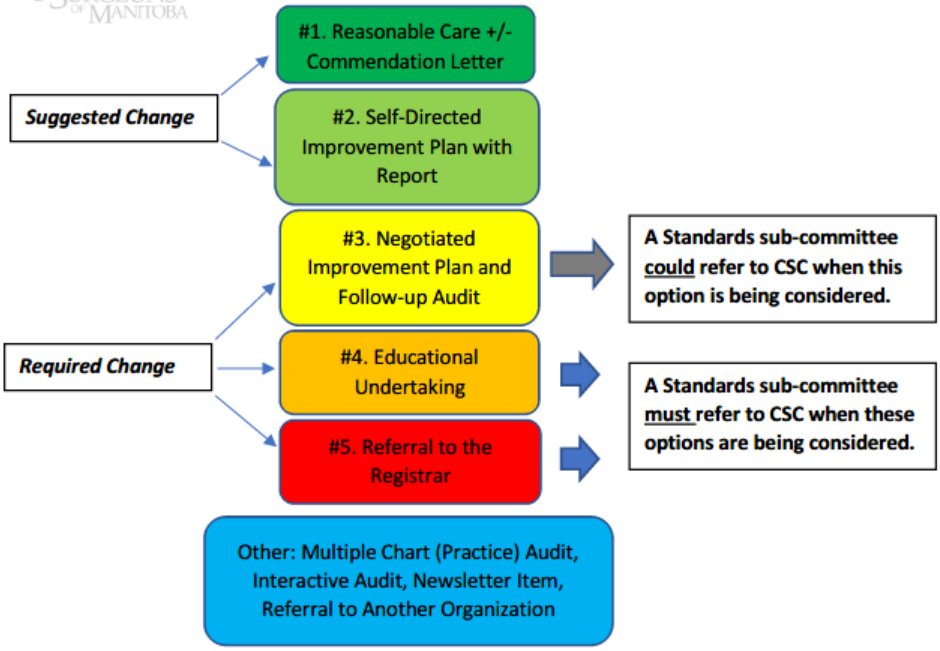
Given that this is the first seven-year cycle for the Quality Improvement Program, there is a need to evaluate each component and ensure that the investment of time and resources is effectively producing the desired outcomes. Category 3, given its long time to completion, requires further review in terms of its value before initiating the next seven-year cycle.

Performance Metrics: Audits and Monitoring (Quality Assurance/Standards)

Purpose: The Audits and Monitoring Program contributes to the legislated requirement of CPSM to supervise the practice of medicine and ensure the competence of the profession by reviewing individual registrant practice through audits.

Key impacts on Patient Safety:

1) CPSM has a duty to supervise the practice of medicine and ensure the competence of its registrants in the interest of patient safety. Reviewing the practice of individual registrants and providing focused feedback offers each registrant the opportunity to improve care. With the new standardized rubric for decision-making, there is an opportunity to measure the impact of an intervention for required change (decision level #3 or #4) in terms of improvement. Demonstrating that CPSM Standards processes result in quality improvement means that we are effectively regulating the profession and improving care for the public. Outcomes #3 and #4 routinely include a follow-up audit at an appropriate interval determined by the Central Standards Committee and therefore the outcomes for each registrant can be tracked for improvement.



2023-2024 PERFORMANCE METRIC:

OUTCOME MEASURE: "Required Change" #3 and #4 outcomes from the Central Standards Committee review of a registrant's audit result in a measurable improvement on follow-up assessment.

Current State: Not measured.

Target: 50% of registrants will demonstrate a measurable improvement on follow-up assessment after a #3 and #4 outcome.

Rationale: The decision rubric used by the Central Standards Committee has only been in effect for one year; as a result, repeat audits after intervention are just starting to happen. Data is slowly being collected and will be usable towards the end of 2023. Achieving the goal of measurable improvement for 50% of registrants with a #3 or #4 outcome is highly dependent upon the engagement and efforts of the individual who needs to make changes to their practice.

Demonstrating measurable change after an intervention in Quality is a powerful indicator of the effectiveness of CPSM's ability to self-regulate, act in the public interest, and improve care for patients.

2) Efficient completion of the audits in the Audits and Monitoring Program (Quality Assurance/Standards) is a benefit to both public safety through the supervision of the practice of medicine, and registrant engagement/satisfaction in the process of reflection and learning. Most registrants express some degree of distress having to engage with a CPSM activity, even if it is under the Department of Quality, therefore timely and predictable processes can reduce stress. CPSM Council has identified that registrant engagement is important to regulatory success.

2023-2024 PERFORMANCE METRIC:

PROCESS MEASURE: The audit process from the date of the audit to addition to the next CSC (Central Standards Committee) agenda will be completed within 30 days.

Current State: Not measured.

Target: 80% of audits will be completed within the 30-day timeline

Rationale: The preparatory steps for an audit take approximately 90 days, including response times for the registrant's pre-audit questionnaire, requests for PHIN (Personal Health Information Number) from Manitoba Health based upon billing data, and arranging of the audit, including securing an auditor and time in their schedule. This can take longer if it is difficult to identify an auditor or if there are limited options and the auditor's schedule is busy. Once the audit is booked, the process is well within the control of CPSM staff in most cases. There are however times when audits are not completed as scheduled for technical issues or auditor availability. These disruptions currently happen in about 2 in 10 audits, thus 80% is an achievable target. Reliable timelines enable CPSM staff to be transparent in their communication with registrants about expectations for the audit process and can reduce the stress for registrants involved in a regulatory review.

Performance Metrics: Prescribing Practices Program

Purpose: The Prescribing Practices Program (PPP) contributes to CPSM's mandate to supervise the practice of medicine and ensure the competence of the profession through educational interventions aimed at improving prescribing and, therein, increasing the quality of care and patient safety.

Key impacts on Patient Safety:

1) The Prescribing Practices Program directly supports registrants who call with a prescribing question or concern. They also respond to inquiries from other health professionals (e.g. pharmacists) and the public. Providing direct advice on prescribing opioids,

benzodiazepines, opioid replacement therapy, and methadone is a valuable and impactful service intended to support safe patient care and encourage improved prescribing practices through case-based learning.

2023-2024 PERFORMANCE METRIC:

PROCESS MEASURE (with target): PPP will respond to 60% of general prescribing advice inquiries within one business day and 90% within two business days.

Current State: Not tracked.

Rationale: The response time to address inquiries from registrants (and other professionals) within 1-2 business days is an *achievable* goal based *on current call volumes*. Should the call volume increase significantly in 2023, achieving this goal may become a challenge. This goal highlights the importance of **timely support** to our registrants regarding prescribing/clinical care concerns. PPP already prioritizes these calls/inquiries and typically responds within two business days, although this has not been formally tracked. Responding to 90% of inquiries within this period is a realistic goal currently. Tracking this metric will further prioritize this function and monitor our ability to meet and maintain this goal. At the same time, the **number of GPA (General Prescribing Advice) cases continues to rise annually**. If it becomes difficult to meet this target, the data can help identify inefficiencies and pitfalls, or highlight the need for further resources as the volume of calls/inquiries continues to rise.

Maintaining timely access to support for registrants' clinical concerns aligns with CPSM & Council organizational priorities.

2) Efficient completion of reviews in PPP is a benefit to both public safety through the supervision of the practice of medicine with quality improvement and registrant engagement/satisfaction in the process of reflection and learning. Most registrants express some degree of distress having to engage in a CPSM activity, even if it is under the Department of Quality. Timely and predictable processes can reduce stress. CPSM Council has identified that registrant engagement is important to regulatory success.

2023-2024 PERFORMANCE METRIC:

PROCESS MEASURE: Medical Examiner cases with serious prescribing concerns identified are completed within 90 business days (PPP intervention completed and case closed).

Current State: Not tracked.

Target: 75% of cases will be completed in the identified timeline.

Rationale: To complete 75% of complex ME cases within 90 days (3 months) is a *stretch* goal to help redefine our process for ME cases and **focus our PPP intervention on cases with serious prescribing concerns that can have the greatest impact on patient safety**. The 3-month window recognizes the time it takes to complete the back-and-forth correspondence needed to gather information and to provide quality case-specific recommendations and guidance (not unlike CI cases).

These process performance measures will help determine how effectively we respond to complex or concerning prescribing issues that directly impact patient safety. A timely response is paramount for high-impact regulation and to support registrants. Some variables are outside of PPP control, such as registrants' response time to our letters or scheduling considerations for coaching/mentorship. This KPI leaves room for 25% of cases that can still be started in a prioritized manner but acknowledges some are so complex that more time is required to complete all necessary correspondence and coaching/mentoring.

While all ME cases require attention, **cases with serious prescribing concerns can be prioritized** for a more timely and greater impact on patient-safety. When concerning prescribing patterns are identified through ME cases, engaging earlier with physicians will ideally impact their current prescribing with patients still under their care. Our intervention (education, coaching, and mentoring) can proactively and positively impact existing patients. Even if 25% of cases are not completed within three months, engaging with these physicians earlier in a prioritized manner still promotes more timely intervention for patient safety.

This KPI flips the focus of our current process where simple to intermediate cases are often addressed first as they are higher volume and require less intensive case review. Historically, complex cases have taken longer to complete as more communication and more detailed medical consultant review is required. Setting this goal and tracking this metric will help PPP *prioritize complex case correspondence first* to begin intervention (above less-concerning cases), while continuing to address intermediate to simple cases in that order. The more serious the concern, the greater the risk to the public.

Performance Metrics: Manitoba Quality Assurance Program (MANQAP)

Purpose: To accredit and ensure high quality and safety in all Manitoba laboratory and diagnostic facilities and Non-Hospital Medical Surgical Facilities (NHMSF).

Key impacts on Patient Safety:

1) MANQAP is contracted by the Manitoba government to ensure independent oversight of the safe operation of all laboratory and diagnostic facilities in Manitoba. Accreditation takes place on a five-year cycle; each year a portion of facilities must be inspected. Operating within the contract's requirements and ensuring compliance with the terms of the agreement is necessary to ensure CPSM delivers on its mandate to protect the public.

Non-Hospital Medical Surgical Facility accreditation is also on a five-year cycle, however, there are no formal contracts or deliverables with the government. Each year, a portion of existing facilities require an update to their accreditation as per their identified five-year cycle. New facilities needing accreditation to open or those enhancing their services, must be reviewed as per the schedule outlined in the CPSM By-Law for Accredited Facilities.

2023-2024 PERFORMANCE METRIC:

OUTCOME MEASURE: MANQAP will be compliant with the deliverables of the Manitoba Health contract and inspect for accreditation purposes, the required number of laboratory and diagnostic facilities in 2023-2024. MANQAP will ensure all required NHMS facilities are inspected for accreditation purposes in alignment with the CPSM By-Law for Accredited Facilities.

Current State: Routine facility accreditation inspections disrupted by COVID have resumed for laboratory and diagnostic facilities. COVID backlogs continue to be addressed. MANQAP is currently on track to complete the required diagnostic inspections in 2023-2024.

Implementation of the new By-Law for Accredited Facilities is moving along after adopting new standards, resulting in the delayed assessment of some NHMS facilities due for inspection in 2022-2023. MANQAP anticipates it will be able to review all new and existing NHMS facilities requiring accreditation inspections in 2023-2024.

Target: > 90% of inspections will be completed by the end of the 2023-2024 fiscal year.

Rationale: Compliance with contractual and By-Law requirements is necessary for CPSM to fulfill its duty to protect the public and ensure patient safety. The majority of laboratory, diagnostic, and NHMS facilities can be reviewed on the schedule outlined by MANQAP however, there are circumstances external to MANQAP that arise, which may result in delays. All delays in accreditation are reviewed and approved by the Program Review Committee. A margin of <10% for incomplete accreditation during identified timeframes is reasonable and within routinely observed limits.

2) Monitoring of Adverse Patient Outcomes (APOs) is an important requirement for ongoing patient safety outlined in the CPSM Accredited Facilities By-Law for NHMSF. MANQAP receives all notifications of APOs, as per the By-Law, and is responsible for ensuring that the event is reviewed in a timely manner to determine if the facility is appropriately managing complications from procedures. This is a core function of the accreditation role in protecting the public and ensuring patient safety.

2023-2024 PERFORMANCE METRIC:

PROCESS MEASURE: Non-emergent APOs will be reviewed by an expert (providing an opinion and recommendation about safety) and the briefing for Program Review Committee will be completed within 14 days of receipt of the complete APO file.

Current State: Not measured.

Target: Reviews will be completed within the identified time 90% of the time.

Rationale: Timely review of APO details by experts enables MANQAP to identify any serious concerns with the safety at a facility where an adverse event has occurred. If the APO review identifies serious concerns with the facility, communication can occur with the Chair of the Program Review Committee, the Assistant Registrar and Program Review Committee for action as appropriate. This timely response ensures appropriate interventions can be made for patient safety. Once MANQAP receives the complete file, much of the process lies within MANQAP's control and therefore, the timeline is reasonable. Emergent APOs would be dealt with on an expedited timeline. MANQAP has recently taken over this role of oversight for NHMSF and therefore, it is important to use our data to reflect and improve upon new processes.

PUBLIC INTEREST RATIONALE:

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

The purpose of performance metrics is to measure how the CPSM is "carry[ing] out its mandate, duties and powers and governs its members". Performance metrics will provide Council with quantifiable performance measurements on what and how the CPSM is carrying out its statutory responsibilities. This data will enable CPSM to make informed decisions on how to better serve and protect the public interest.

The College of Physicians & Surgeons of Manitoba

CPSM QUALITY DEPARTMENT PERFORMANCE METRICS

Dr. Ainslie Mihalchuk, Assistant Registrar - Quality


Quality

Quality Department

PHYSICIAN HEALTH PROGRAM

QUALITY IMPROVEMENT PROGRAM

AUDITS AND MONITORING (QUALITY ASSURANCE/ STANDARDS

PRESCRIBING PRACTICES PROGRAM

MANQAP AND NHMSF

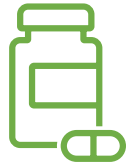
The Process

PHYSICIAN HEALTH PROGRAM

QUALITY IMPROVEMENT PROGRAM

AUDITS AND MONITORING (QUALITY ASSURANCE

PRESCRIBING PRACTICES PROGRAM



MANQAP AND NHMSF

Physician Health Program

SELF-REPORTING (OR COLLEAGUE) TO PHP

OUTCOME MEASURE

The number of referrals coming from registrants about self/colleagues to the PHP.

CURRENT STATE

41% of referrals are from registrants.

TARGET FOR 2023/2024

Increase referrals from registrants by to **50%** (an increase of 10%).

Physician Health Program

OUTCOME MEASURE RATIONALE

Proposing a modest increase given the difficulty in changing registrant beliefs and behaviors around reporting to CPSM.

Physician Health Program

TIMELY RESPONSES & INTERVENTIONS

PROCESS MEASURE

Time to respond with initial contact to urgent referrals (high likelihood there is a relevant health issue which may be causing impairment but does not include emergent cases where there is immediate risk to patient safety).

CURRENT STATE

Not currently measured.

TARGET FOR 2023/2024:

For urgent health concerns, contact initiated with the registrant on the same business day the referral is received, 90% of the time.

90%

Physician Health Program

PROCESS MEASURE RATIONALE

- Timely response to new referrals of an urgent nature supports CPSM and PHP's mandate to protect the public.
- 9 out of 10 times allows for the fact that there will always be circumstances where the registrant may not be able to respond, or PHP is dealing with a different urgent matter and cannot get to a new referral the same day.
- Historically, minimal metrics were kept in Physician Health.
- In the last year, we have been proactively building and enhancing database capabilities in anticipation of the goal of using data to guide performance. The capability to track and report on these timelines is now in place.

Quality Improvement Program

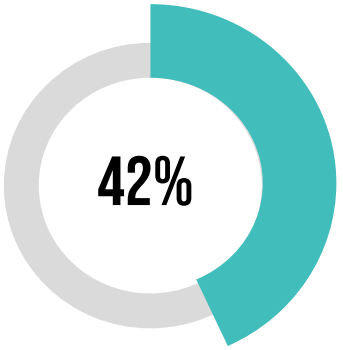
REVIEW COMPLETION

OUTCOME MEASURE

CPSM will complete reviews of 95% of all applicable registrants by the end of the first seven-year cycle (December 31, 2025).

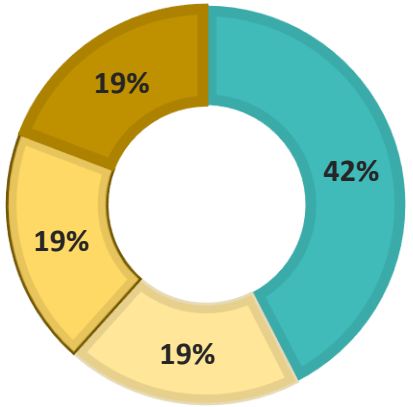
CURRENT STATE

In the program's 4th year, **42%** of registrants have completed the program (1056/2529 registrants).



TARGET

To complete **19% of registrants *per annum*** for the remaining three years of the program.



Quality Improvement Program

OUTCOME MEASURE RATIONALE

- Completing this legislated activity of supervising the practice of medicine is critical to CPSM's self-regulatory duty.
- This metric is intended to demonstrate the program's achievement in staying on track with projected volumes per annum.
- Each year, there are a variety of valid reasons that participants need to defer their participation.
- It is conceivable that despite the program's best efforts, a small percentage of registrants will be incomplete by the end of December 31, 2025, though it is expected that this will be <5% of the total cohort (125 registrants).

Quality Improvement Program

TIMELY PROCESSES

PROCESS MEASURE

QI processes will be completed:

WITHIN 30 DAYS FOR (60%) FOR CATEGORY 1 PARTICIPANTS

WITHIN 90 DAYS FOR (35%) FOR CATEGORY 2 PARTICIPANTS

WITHIN 240 DAYS FOR (5%) FOR CATEGORY 3 PARTICIPANTS

CURRENT STATE: NOT CURRENTLY MEASURED

TARGET

Each category will be completed within the identified timelines 90% of the time.

PROCESS MEASURE RATIONALE

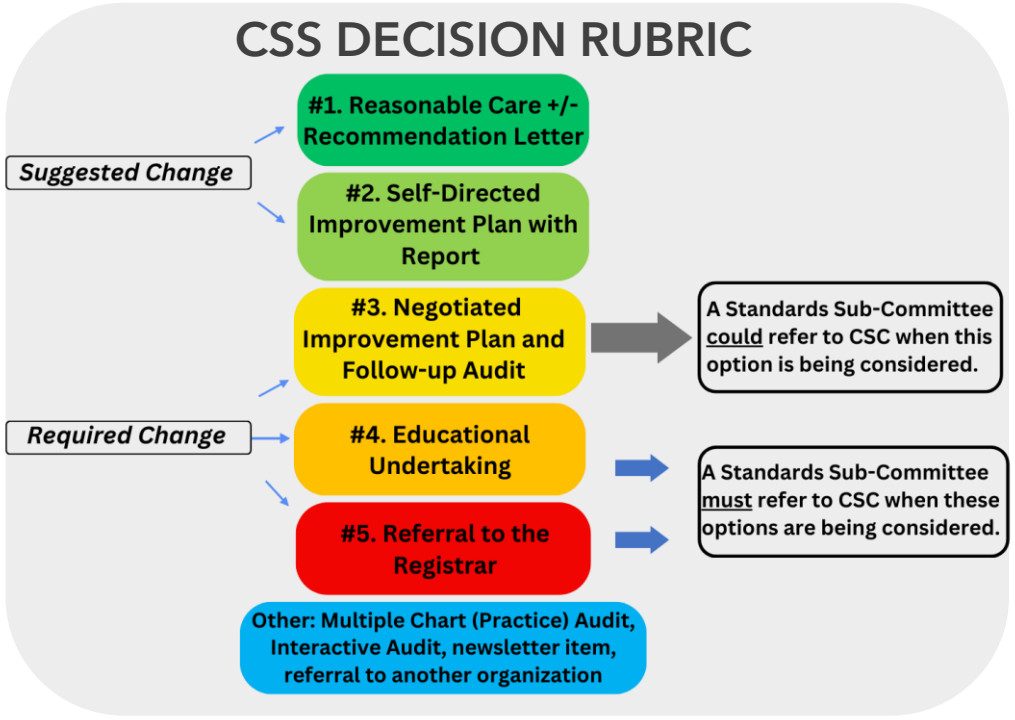
- **Category 1** process completion is dependent only on CPSM staff and therefore the completion time is much shorter than Category 2 or 3.
- **Category 2** requires an audit which adds significant time.
- **Category 3** requires an MCC 360 review which adds considerable length to the process. Currently, Category 3 interactive audit and MCC 360 processes happen in series and not in parallel and the MCC process is external to CPSM; we do not have influence over those timelines. The interactive audit requires the coordination of the schedules for two auditors and the participant, which can be challenging.
- The opportunity to track timelines and efficiencies enables the QI program staff to assess and implement internal quality improvements as well as communicate clearly with registrants regarding timelines for completion. There is always the potential for issues to arise in the process, with delays on the registrant or the CPSM side.
- Nine out of 10 times to reach the desired timelines for the process has been identified as achievable by Quality Improvement Program staff. Given that this is the first seven-year cycle for the Quality Improvement Program, there is a need to evaluate each component and ensure that the investment of time and money is effectively producing the desired outcomes.
- Category 3, given its long time to completion, requires further review in terms of its value prior to the initiation of the next seven-year cycle.

Audits & Monitoring (Quality Assurance/Standards)

MEASURING IMPROVEMENT

OUTCOME MEASURE

Required Changes (decisions ***#3 and #4***) outcomes from the Central Standards Committee review of a registrant's audit result in a measurable improvement on follow-up assessment.

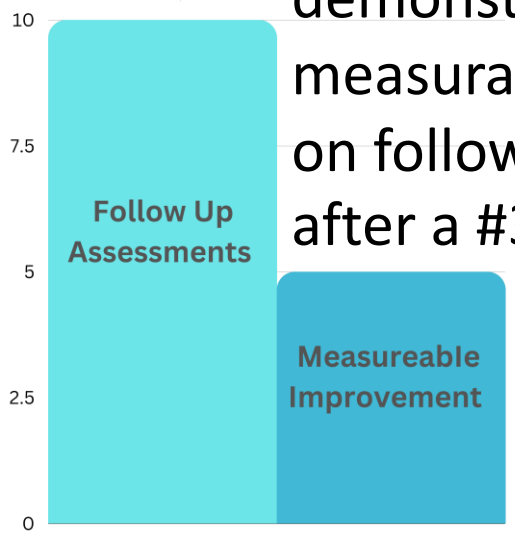


CURRENT STATE

Not measured.

TARGET FOR 2023/2024

50% of registrants will demonstrate a measurable improvement on follow-up assessment after a #3 or #4 outcome.



OUTCOME MEASURE RATIONALE

- The decision rubric used by the Central Standards Committee has only been in effect for one year; as a result, repeat audits after intervention are just starting to happen.
- Data is slowly being collected and will be used towards the end of 2023. This is a metric we hope to be able to develop more clearly by the end of 2023 once more of the required change (#3 and #4 decisions) follow-up audits have occurred.
- Demonstrating measurable change after intervention in Quality is a powerful indicator of the effectiveness of CPSM's ability to self-regulate, act in the public interest, and improve care for patients.

Audits & Monitoring (Quality Assurance/Standards)

TIMELY & PREDICTABLE PROCESS

PROCESS MEASURE

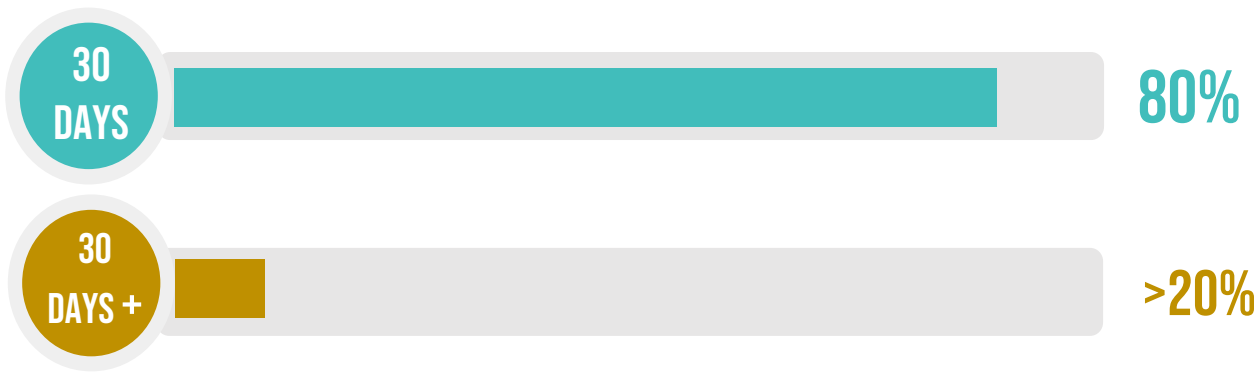
The audit process **from** *audit completion* ***to*** *audit addition to CSC meeting agenda* will be completed within 30 days.

CURRENT STATE

Not measured.

TARGET

80% of audits will be completed within **30 days.**



PROCESS MEASURE RATIONALE

- The preparatory steps for an audit take approximately **90 days.**
- **This** includes response times for the registrant's pre-audit questionnaire, requests for PHIN information from Manitoba Health based upon billing data, and arranging of the audit, including securing an auditor and time in their schedule.
- This can take longer if it is difficult to identify an auditor or if there are limited options and the auditor's schedule is busy.

- ***Once the audit is booked, the process is well within the control of CPSM staff in most cases.*** There are however times when audits are not completed as scheduled for technical issues or auditor availability. These disruptions currently happen in about 2 in 10 audits, thus 80% is an achievable target.
- Reliable timelines enable CPSM staff to be transparent in their communication with registrants about expectations for the audit process and can reduce the stress for registrants involved in a regulatory review.

Prescribing Practices Program (PPP)

RESPONSE TIME FOR GENERAL PRESCRIBING ADVICE

OUTCOME MEASURE

PPP will respond to general prescribing advice (GPA) inquiries within **one business day 60% of the time** and **two business days 90% of the time**.

CURRENT STATE

Not currently measured.

TARGET

Respond to GPA inquiries within:

OUTCOME MEASURE RATIONALE

- The response time to address inquiries from registrants (and other professionals) within 1-2 business days is an *achievable* goal based ***on current call volumes***.
- Should the call volume increase substantially in 2023, achieving this goal may become a challenge.
- This goal highlights the importance of providing **timely support** to our registrants re: prescribing/clinical care concerns. PPP already prioritizes these calls/inquiries and typically responds within 2 business days, although this has not been formally tracked.
- Responding to 90% of inquiries within this timeframe is a realistic goal at this time.
- Tracking this metric will further prioritize this function and monitor our ability to meet and maintain this goal while the **number of GPA cases continues to rise annually**. If it becomes difficult to meet this target, the data can help identify inefficiencies and pitfalls, or highlight the need for further resources as the volume of calls/inquiries continues to rise.

Prescribing Practices Program:

ADDRESSING SERIOUS PRESCRIBING CONCERNS IN A TIMELY MANNER

PROCESS MEASURE:

Medical Examiner cases that identify serious prescribing concerns will be completed within 90 business days. (Completion includes PPP intervention and case closed.)

CURRENT STATE

Not formally tracked.

TARGET

75% of cases with serious prescribing concerns will be completed within **90 business days**.

- 75% completed in 90 days
- 25% completed <90 days

PROCESS MEASURE RATIONALE

- To complete 75% of complex ME cases within 90 days (3 months) is a *stretch* goal to help redefine our process for ME cases and **focus our PPP intervention on cases with serious prescribing concerns that can have the greatest impact on patient safety**.
- The 3-month window recognizes the time it takes to complete the back-and-forth correspondence needed to gather information and to provide quality case-specific recommendations and guidance (not unlike CI cases).
- These process performance measures will help determine how effectively we respond to complex or concerning prescribing issues that directly impact patient safety.
- A timely response is paramount for high-impact regulation and to support registrants. Some variables are outside of PPP control, such as registrants' response time to our letters or scheduling considerations for coaching/mentorship.
- This KPI leaves room for 25% of cases that can still be started in a prioritized manner but acknowledges some are so complex that more time is required to complete all necessary correspondence and coaching/mentoring.

MANITOBA QUALITY ASSURANCE PROGRAM: 0042

COMPLYING WITH ACCREDITATION EXPECTATIONS

OUTCOME MEASURE:

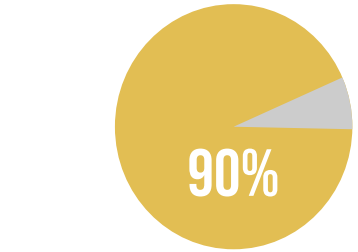
1. MANQAP will inspect the required number of laboratory and diagnostic facilities for accreditation purposes in compliance with the Manitoba Health contract.
2. MANQAP will ensure all required NHMS facilities are inspected for accreditation purposes in alignment with the CPSM By-Law for Accredited Facilities.

CURRENT STATE: on track

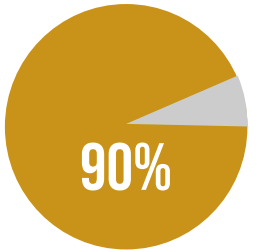
1. Laboratory and diagnostic facility accreditation inspections disrupted by COVID have resumed. COVID backlogs continue to be addressed.
2. By-Law for Accredited Facilities implementation delayed assessments due for inspection in 2022-2023. All new & existing facilities requiring inspections in 2023-2024 are expected to be completed.

TARGET

> 90% of inspections will be completed by the end of the 2023-2024 fiscal year.



Laboratory & Diagnostic Inspections Completed



NHMS facility inspections completed.

OUTCOME MEASURE RATIONALE

- Compliance with contractual and By-Law requirements is necessary for CPSM to fulfill its duty to protect the public and ensure patient safety.
- The majority of laboratory, diagnostic, and NHMS facilities can be reviewed on the schedule outlined by MANQAP however, there are circumstances external to MANQAP that arise, which may result in delays.
- All delays in accreditation are reviewed and approved by the Program Review Committee. A margin of <10% for incomplete accreditation during identified timeframes is reasonable and within routinely observed limits.

MANITOBA QUALITY ASSURANCE PROGRAM: 0044

ADVERSE PATIENT OUTCOMES (APO)

PROCESS MEASURE:

Non-emergent APOs will be reviewed by an expert (providing an opinion and recommendation about safety) and the briefing for the Program Review Committee **will be completed within 14 days of receipt of the complete APO file.**

CURRENT STATE

Not measured.

TARGET

Reviews will be completed within 14 days of receipt of the complete APO file, 90% of the time.

APO REVIEWS COMPLETED IN 14 DAYS

PROCESS MEASURE RATIONALE

Timely review of APO details by experts enables MANQAP to identify any serious concerns with the safety at a facility where an adverse event has occurred.

If the APO review identifies serious concerns with the facility, communication can occur with the Chair of the Program Review Committee, the Assistant Registrar and Program Review Committee for action as appropriate.

This timely response ensures appropriate interventions can be made for patient safety. Once MANQAP receives the complete file, much of the process lies within MANQAP's control and therefore, the timeline is reasonable.

Emergent APOs would be dealt with on an expedited timeline. MANQAP has recently taken over this role of oversight for NHMSF and therefore, it is important to use our data to reflect and improve upon new processes.

These performance metrics allow the Quality department to measure and evaluate the **continued competence** of the medical profession.

The department's **proactive** and for-cause interventions provide **feedback to registrants and foster learning** to support improved practice and patient care.

COUNCIL MEETING
MARCH 22, 2023
BRIEFING NOTE

SUBJECT: Quality Prescribing Rules Review Working Group Update

RECOMMENDATION:

Council receives the Briefing Note for discussion.

KEY MESSAGES:

The Working Group will recommend at the June Council Meeting approval for distribution for consultation of new:

1. Standard of Practice – Prescribing Requirements
2. M3P form for prescribing in all formats (electronic, handwritten, or verbal)
3. Practice Direction on Electronic Transmission of Prescriptions
4. Practice Direction – Prescribing by Clinical Assistants and Physician Assistants

SUMMARY:

A Working Group, led by Dr. Shenouda, including other regulators was established for the purpose of conducting a Quality Prescribing Rules Review. It is anticipated that the Working Group's recommendations will be submitted in June to the Councils of the CPSM, Pharmacists, Registered Nurses, and dental and veterinary regulators.

The goal is to review and update the rules for quality prescribing and to make permanent the changes to prescribing that were introduced temporarily during COVID. The new rules will be contained in a new consolidate general Standard of Practice for Prescribing Requirements and a Practice Direction for Electronic Transmission of Prescriptions. The goal is also to clarify the prescribing authority of clinical and physician assistants.

The matters addressed are:

1. Verbal Prescribing of all Medications;
2. Permit Pharmacists to Transfer Prescriptions to other Pharmacists, including out of province;
3. M3P Future;
4. Update and combine the Facsimile and Electronic Transmission Prescription Practice Directions;
5. Update the Standards of Practice for Prescribing Requirements;

6. “Prescribing” in the Community and “Ordering” in the Hospital;
7. New Practice Direction on Prescribing by Clinical Assistants and Physician Assistants
8. Transmitting Prescriptions by E-Mail;
9. Dispensing Physicians Practice Direction;
10. Pharmacists Extending Prescriptions for All CDSA Medications
11. Addition of certain codeine containing products to the M3P drug list

QUESTIONS FOR COUNCIL CONSIDERATION:

1. How do these changes ensure efficient and safe prescribing?
2. Are there any prescribing concerns that are not being addressed?
3. What are the impediments to greater electronic prescribing?
4. Do the other regulators have concerns with the proposal?
5. What are the implications on patient care and the health care system is physician and clinical assistants cannot prescribe controlled drugs and substances?

BACKGROUND

The Quality Prescribing Rules Review is a Strategic Organizational Priority chosen by Council led by Dr. Shenouda. It includes other regulators in Manitoba.

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

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

UPDATE:

There are many recommended changes to improve the quality of prescribing in the province that the Working Group will soon recommend to the Councils of CPSM, Pharmacists, Registered Nurses, and the dental and veterinary regulators.

The expected requirements for prescribing are currently scattered through out the Standard of Practice on Prescribing Requirements and four Practice Directions. While much of this information is duplicated several times, unfortunately not all of this material is consistent. This does not include the two Standards for Prescribing Opioids and Benzodiazepines/Z-Drugs, nor the Practice Direction for Prescribing Methadone and Buprenorphine/Naloxone.

At this time, the plan is to consolidate the general prescribing into one CPSM Standard of Practice and one joint Practice Direction for Electronic Transmission of Prescriptions with the five regulators. There will also be a Practice Direction for Accessing Drugs in Rural and Remote Underserved Populations that is joint with various professions. Finally, there will also be a Practice Direction to outline the authority and practices for Clinical Assistant and Physician Assistant Prescribing.

There are several items that need finalization prior to submitting for approval. Plans are also required for implementation and system issues might need to be addressed prior to implementation. Accordingly, this is not ready to proceed to CPSM Council in March but should be ready for the June meeting of Council.

Items Anticipated to be Ready to Proceed to Council in June

The following are items anticipated to be ready to proceed in June to CPSM Council and other regulators in June for approval:

1. Verbal Prescribing of all Medications

Permit verbal prescribing for all non-M3P medications. The current status permit verbal ordering of most medications, other than certain drugs under the federal *Controlled Drugs and Substances Act*. The recommendation is verbal prescribing of all medications, (including those in the *Controlled Drugs and Substances Act*) be permitted to ensure access, yet procedures be tightened so to ensure patient safety. M3P drugs will have special rules for verbal prescribing in very limited circumstances (as below).

The rules for verbal prescribing will now be contained in the Standard of Practice for Prescribing Requirements.

2. Permit Pharmacists to Transfer Prescriptions to Other Pharmacists, including Out of Province

Currently, some medications can not be transferred between pharmacist in different pharmacies (Tylenol 3, opioids, Concerta, etc).

It is recommended that this exemption be implemented, with the requirement for a pharmacist to notify a prescriber simply that an out of province transfer is completed, to help ensure continuity of care. A prescriber could, at their discretion, contact a pharmacy for additional information in the interest of patient safety. It will be specified in guidance to healthcare professionals that additional information can be disclosed on a case-by-case basis. This is seen to be important for access to prescribed medicine and can be performed safely.

The College of Pharmacists of Manitoba will be required to alter their rules to permit this. This initiative has only been recently available due to the new federal exemption to s.56 of the *Controlled Drugs and Substances Act* which makes this no longer an offence if provincial regulators permit this.

3. M3P Future

a. Retain M3P as a separate class of drugs with prescribing requirements that are in addition to the regular prescribing requirements.

b. Verbal prescribing of M3Ps prescriptions to be permitted under limited conditions. These rules will be included in the Standard of Practice for Prescribing Requirements. Specifically, it establishes the contents of the prescription verbally relayed to the pharmacist. This is pretty much everything that a regular prescription includes other than signature and date.

   The process for verbal prescribing M3P drugs will be as follows:

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

c. Eliminate the paper M3P pads. Prescribers will have the option to write an M3P prescription on paper utilizing the approved form and printing it themselves. Previously printed pads may continue to be used until all previously printed pads are utilized.

   In the beginning days of the COVID-19 pandemic the Colleges of Physicians, Pharmacists, and Registered Nurses created a protocol for M3P drugs prescriptions to be faxed directly to the pharmacy instead of a triplicate sheet being physically handed to a patient. This must be updated to reflect the post-pandemic world and adopted permanently.

   The new approved form will be included on the CPSM and CPhM websites. The working Group asked if the required content could be approved instead of a specific form. As this may present a legal barrier regarding the Pharmaceutical Regulations, CPSM will review potential options with CPhM and discuss at a future WG meeting.

[1] This requirement cannot be sufficiently satisfied by a prescriber leaving a voice message. If a voice message is left by a prescriber, a direct callback number must be included to facilitate the pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a pharmacist speaks directly with the prescriber to verify the order. No delegation to an agent is permitted.

d. The rules for prescribing M3P are currently in their own Practice Direction. As part of the consolidation of the information that is scattered in various documents, the rules for prescribing M3P will be included in the Standard of Practice for Prescribing Requirements.

e. Eliminate the application and CPSM approval to prescribe M3P (already implemented). This was described in detail to Council in December 2022 and will not be repeated here.

f. The Manitoba Dental Association uses M3P pads and has adopted many of the practices of CPSM-CPhM-CRNM, though it is not one of the regulators that has established this and their list of M3P drugs has not changed in several years. Contact is required with the Manitoba Dental Association to advise them of these changes to M3P.

4. Update and combine the Facsimile and Electronic Transmission Prescriptions Practice Directions

a. Joint with CPhM, CRNM, MDA (dental), and MVMA (vets)

b. An earlier version was sent to Council in December. This has been revised to eliminate the reference to e-mail prescribing (see explanation below.)

c. The proposed requirement to include a treatment goal and/or clinical indication(s) and/or diagnosis in non-M3P prescriptions is now deleted. CPhM requested that indication should be on all prescriptions. As this would be an administrative burden, at a future meeting the WG will discuss if this could be a requirement for new prescriptions only.

5. Update the Standard of Practice for Prescribing Requirements

a. Include section on M3P Drugs. The Schedule for M3P drugs will be attached to this Standard. The expectations for prescribing M3P drugs are moved into the Standard of Practice on Prescribing and the current Practice Direction for M3P Prescribing will need to be repealed. This prevents duplication and lack of consistency. It also consolidates the prescribing rules rather than the scattered approach in various documents.

b. Include section on Verbal Orders. The expectations on verbal prescribing were included in an obscure Practice Direction entitled “Doctor - Pharmacist Relationship”.

Again, for consolidation, the verbal prescribing has been moved to this Standard, and has been edited to ensure consistency and no duplication.

c. Include information on statutory requirements on Pharmacist's dispensing. There are certain statutory rules governing dispensing that prescribers may not be aware of and have led to friction between the professions. These include federal rules where the pharmacist has no discretion such as certain re-fills, repeats, and part-fills for different drugs and controlled substances.

d. The proposed requirement to include a treatment goal and/or clinical indication(s) and/or diagnosis in non-M3P prescriptions is now deleted. (As this would be an administrative burden, at a future meeting the WG will discuss if this could be a requirement for new prescriptions only.)

e. A new application section provides that this Standard applies to both prescribing in the community and what are called "orders" in a hospital. It also makes clear what specific rules on prescribing do not apply in a hospital/PCH/institutional setting.

6. "Prescribing" in the Community and "Ordering" in the Hospital

There is no legal definition of orders in the RHPA or the Regulations. The reserved act is **prescribe** which means "to issue a prescription for a dental appliance, drug, vaccine, vision appliance or wearable hearing instrument." **Prescription** means "in respect of a drug or vaccine, a direction to dispense a stated amount of a drug or vaccine specified in the direction for the individual named in the direction". The law considers both prescribing in the community and in the hospital to be the same. This has been blurred in the past in the Standard of Practice and the Practice Directions on prescribing.

These documents are being revised with a view to explicitly establishing the expectations for prescribing in either setting. Many but not all requirements are the same, but the prescribing in the community has further requirements for patient safety. Prescribing in a hospital or healthcare facility has numerous different components and is part of team-based care and the institutions' rules. For instance, some of the requirements for the community prescribing are to prevent diversion of controlled substances– something that is not as applicable in a hospital setting where controlled substances are administered directly by a health care professional at each time.

7. New Practice Direction on Prescribing by Clinical Assistants and Physician Assistants

a. The prescribing by PAs and CAs has been the source of much misunderstanding, debate, and lack of clear authority. Difficulties have arisen in federal First Nations where the

federal government has taken the position that CAs and PAs may not prescribe controlled drugs and substances since they are not physicians, even though the federal act states that medical practitioners as defined by the provincial law may prescribe. CPSM takes the position that under its regulations, CAs and PAs practice medicine as medical practitioners and therefore can prescribe (subject to various limits).

A new Practice Direction on CA and PA prescribing communicates the authority for prescribing and establishes the expectations for CA and PA prescribing all drugs and vaccines. Much of this information is included in the regulation, but that is difficult to access, so it will be included in the Practice Direction. It is critical to note that the prescribing will be in accordance with the contract of supervision which establishes different levels of prescribing. The prescribing will also be individualized by the supervising physician depending upon the knowledge, skill, and judgement of the CA and PA and the scope of practice of both the supervising physician and the CA and PA.

b. The Practice Direction is organized to first establish the authority for prescribing, the ability or rules for prescribing, and the prescription contents.

It should be noted that the working group will discuss this issue at its meeting on March 16, 2023 and an update will be provided to Council at the March meeting.

8. Transmitting Prescriptions by E-Mail

Transmitting prescriptions by e-mail will not be one of the changes the Working Group initially thought it might be able to implement. Unfortunately, as the Working Group explored this in detail, the technological requirements grew along with the complexity of interconnecting all prescribers with all pharmacists, verifying both parties, keeping records, and creating encryption.

The Ontario Government also just recently announced that it would eliminate faxes between healthcare professionals through a five-year project, indicating its complexity. While it was important to consider eliminating faxes, it became apparent that a replacement is not readily available.
https://www.cbc.ca/news/canada/toronto/ontario-fax-machines-health-care-1.6734810

CPSM and CPhM will work with Digital Health of the Province to determine any possible technical solutions that can be introduced province-wide to permit emailing of prescriptions and abandon faxes. We have been advised that there are some pilot projects underway using new electronic transmission technology.

9. Dispensing Physicians Practice Direction

This Practice Direction establishes the rules and processes in the rare instances that a physician will dispense drugs directly to a patient under very strict conditions when no pharmacist is available. CPSM has checked its records and found that this has been utilized a number of years ago (2007) in a few locations such as Snow Lake, Gillam, and Grand Beach at the summer cottage for physicians. Apparently, none of these locations have physicians that have dispensed drugs in recent years. The Working Group also requested that CRNM be contacted to determine if there are any dispensing nurses, as this may be permitted per pharmacy legislation.

This is a joint Practice Direction with the College of Pharmacy. It is recommended that this Practice Direction be repealed. The Rural, Remote, and Underserved Populations: Access to Prescribed Medications Practice Direction provides the process for access to drugs in similar situations but relies upon different healthcare professionals.

10. Pharmacists Extending Prescriptions for All CDSA Medications

Currently, pharmacists can extend or renew most prescriptions. However, pharmacists cannot extend or renew prescriptions for drugs covered under the *Controlled Drugs and Substances Act*. Under very limited circumstances, a pharmacist may extend or renew a benzodiazepine prescription.

CPSM Council inquired at its December meeting as to the possibility of pharmacists being able to extend or bridge a prescription for a short duration if the prescribed quantity has been dispensed. This is for those situations in which the pharmacist is unable to contact the prescriber and in the interest of continuity of care, the patient should continue to receive the drugs for a short period. This might only be two to three days or even up to seven days perhaps.

Currently the Federal Section 56 (1) exemptions to the CDSA allows the CPhM to permit pharmacists to extend all CDSA prescriptions. However, provincial regulations have barriers to extending this for M3P drugs. It is our understanding the CPhM could provide a direction to all pharmacists establishing the expectations for extending prescription for non-M3P CDSA medications (ie, Concerta, Tylenol 3).

The statutory scheme is included in the federal *Controlled Drugs and Substances Act* and the provincial *Pharmaceutical Regulation* which is applicable to pharmacists. The CPhM legal counsel might want to consider the legal impediment in that regulation – namely that every M3P prescription must be signed by the authorized prescriber (CPSM registrant) prior to being dispensed by the pharmacist.

If this is indeed an impediment, then the CPhM and CPSM Councils might consider recommending to Government that section 77 of the *Pharmaceutical Regulation* be amended to permit

pharmacists to extend prescriptions for M3P drugs. CPSM and CPhM will review legal options and attempt to jointly engage government pending this review.

11. Addition of certain codeine containing products to the M3P drug list

CPSM Council had asked that, in the interest of patient safety, the Quality Prescribing Rules working group consider adding all codeine containing products which cannot currently be prescribed by a pharmacist to the M3P drug list. Products which may currently be prescribed by a pharmacist are referred to as "exempted codeine preparations", and include Tylenol #1 with codeine^{R}, Robaxacet-8^{R}, and Calmylin with Codeine^{R}. It is important to note that, from this list, only Tylenol #1 is commonly prescribed.

Exempted codeine preparations are defined as products containing codeine with up to 8 mg/solid oral dosage form or up to 20 mg/30 ml of liquid + 2 or more active non-narcotic ingredients.

Although this has been discussed, the working group has not reached a consensus. This will be addressed at an upcoming meeting. The College of Pharmacists requested CPSM provide further information to support the need for this change.

RECOMMENDATION

It is anticipated that at the June meeting of Council, the Working Group will recommend CPSM Council approve the following documents for distribution to the public, stakeholders and registrants for consultation:

1. new Standard of Practice – Prescribing Requirements, including Schedule of M3P Drugs, as attached
2. new M3P form for prescribing in all formats (electronic, handwritten, or verbal)
3. new Practice Direction on Electronic Transmission of Prescriptions, as attached
4. new Practice Direction – Prescribing by Clinical Assistants and Physician Assistants, as attached

It is also anticipated that concurrently the CPSM Working Group will recommend that CPSM Council repeal these documents:

1. current Standard of Practice – Prescribing Requirements
2. current Practice Direction - M3P
3. current Practice Direction – Electronic Transmission of Prescriptions
4. current Practice Direction – Facsimile Transmission of Prescriptions
5. current Practice Direction – Dispensing Physicians
6. current Practice Direction – Doctor/Pharmacist Relationship

It is anticipated the CPSM Working Group will also recommend to Council that it:

1. recommend to Government to revise section 5.8 of the *CPSM General Regulation* to permit the Councils of CPSM and CPhM to establish the appropriate regulatory oversight for M3P prescribing. (Note: regulations under the *Pharmaceutical Act* will also require review to determine if similar amendments are required).

2. recommend to Government to revise the *Interpretation Act* definition of physician or duly qualified medical practitioner to include PAs and CAs.

3. CPhM and CPSM Councils might consider recommending to Government that section 77 of the *Pharmaceutical Regulation* be amended to permit pharmacists to extend prescriptions for M3P drugs. Caveat - this is subject to CPhM agreeing of course.

Consultation

It is anticipated these changes to prescribing should receive the input of the registrants, stakeholders, and the public. The consultation period will be discussed.

Implementation

The implementation of some of these changes may take time and may require system changes. Also, the changes will be across many professions and almost all areas of medical practice. An implementation and communication plan will be required.

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

Prescribing medication is major responsibility of registrants. The public is dependent upon safe, efficient, and reliable prescription of medicine. Ensuring appropriate prescribing Standards of Practices and Practice Directions is a core responsibility of Council to govern members in a manner that serves and protects the public interest.

A good working relationship between the prescriber and the dispenser is critical for ensuring the joint goal of access to safe medication to the patient, whatever their location (hospital, community, rural and remote, and northern First Nations). Practitioners working in all these locations have been involved in the working group to ensure that the patients residing in those communities will have their interests served by providing access to safe prescribing and medication in what can be unique circumstances.

Practice Direction

Electronic Transmission of Prescriptions

DRAFT

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 registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act.*

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

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

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

Purpose

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

1. Definition and Application

"Electronic transmission " is the communication of an original prescription or refill authorization by electronic means, to include computer-to-computer, computer-to-facsimile machine[1], facsimile machine to facsimile machine or facsimile machine to computer which contains the same information it contained when the authorized prescriber transmitted it, but does not include verbally transmitted prescriptions.

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

[1] For instance, a prescription sent by Accuro is actually converted into a fax and sent to the pharmacy's fax machine now.

2. Electronic Transmission of Prescriptions

2.1. Principles

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

2.1.1.a. the process must maintain confidentiality. It must do so by either facsimile or closed e-prescribing system.[2] Prescribers and pharmacists are jointly responsible for maintaining the confidential nature of electronic transmission.

2.1.1.b. the accuracy and authenticity of the prescription must be able to be validated.[3]

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

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

2.2 Shared Responsibility

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

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

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

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

2.3. Safeguards

2.3.1. The following additional safeguards apply to electronic prescriptions:

2.3.1.a. All prescriptions transmitted electronically (except veterinary prescriptions) must be entered into the Drug Program Information Network (DPIN) to enhance patient care and safety, and to restrict opportunities for potential prescription fraud.[4]

2.3.1.b. After transmission, the prescriber must ensure that the original prescription is invalidated to ensure it is not transmitted elsewhere at another time. A

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

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

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

prescription record must be retained in accordance with the prescriber's regulatory body.

2.3.1.c. Pharmacists must ensure the electronic and facsimile equipment at the pharmacy is under the control of the pharmacist so the transmission is received and only handled by staff in the dispensary in a manner which protects the patient's privacy and confidentiality.[5] Prescriptions, including any relevant prescription information received by electronic transmission must be appropriately filed by the pharmacist in accordance with CPhM's record keeping requirements.

3. Content of Electronic Prescriptions

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

- 3.1.1. The prescriber's printed name, signature, practice address, and Registration number.
- 3.1.2. The patient's name and either date of birth or Personal Health Information Number (PHIN) (For M3P drugs, also include patient's address and date of birth); [6]
- 3.1.3. The name of the drug;
- 3.1.4. The drug strength, quantity, and formulation (tablet, liquid, patch);
- 3.1.5. The dose and directions for use;
- 3.1.6. The full date the prescription was issued (day, month, and year);
- 3.1.7. Refill instructions, including dispensing intervals, if applicable;
- 3.1.8. The time and date of prescription transmission;
- 3.1.9. The name and address of the one pharmacy intended to receive the prescription;
- 3.1.10. Method to contact the prescriber – telephone number, email address, or facsimile number.
- 3.1.11. Signed certification that:
  - 3.1.11.a. the prescription represents the original of the prescription drug order,
  - 3.1.11.b. the addressee is the only intended recipient and there are no others, and
  - 3.1.11.c. the original prescription will be invalidated, securely filed, and not transmitted elsewhere at another time.

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

3.3. If the prescriber is an associate registrant (Clinical Assistant, Physician Assistant, or Resident), see the Practice Direction on Prescribing Drugs and Vaccines by Clinical Assistants and Physician Assistants. Residents must include the same contents as Section 9 of that Practice Direction.

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

[6] Veterinary prescriptions are exempt from PHIN and date of birth

Standard of Practice

Prescribing Requirements

DRAFT

Initial Approval: **Effective Date:**

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

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

PREAMBLE

Medicine and Pharmacy are two professions which are often jointly involved in the management of the same patient. Unfortunately, the pharmacist and physician often have very little direct contact with each other in this matter, as all contact is usually through the written prescription or by verbal order from the physician. The two individuals may never have met each other and may not totally understand each other's responsibilities. This attempts to improve this liaison and ensure better access to quality safe prescribing for Manitobans.

1. Application

1.1. Prescribe[1] and Prescription[2] includes both prescriptions in the community and what are commonly called “orders” in hospital and residential health care institutions. Only the requirements in section 10 apply to prescribing in hospitals and residential health care institutions.

[1] Prescribe is defined as “to issue a prescription for a dental appliance, drug, vaccine, vision appliance, or wearable hearing instrument.” *RHPA* s. 3

[2] Prescription is defined as “in respect of a drug or vaccine, a direction to dispense a stated amount of a drug or vaccine specified in the direction of the individual named in the direction.” RHPA, s. 3

PART A – PRESCRIBING IN THE COMMUNITY

2. Before Prescribing

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

2.2 Before prescribing a drug, prescribers **must**:

- 2.2.1 complete an appropriate clinical assessment of the patient;[3]
- 2.2.2 document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information;
- 2.2.3 consider the risks and benefits of prescribing the chosen drug, including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions; and
- 2.2.4 obtain informed consent.

3. Content of Prescriptions

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

- 3.1.1. the prescriber's printed name, signature[4], practice address, and CPSM registration number;
- 3.1.2. the patient's name and either date of birth or personal identification number (PHIN); (for M3P drugs also include patient's address and date of birth)
- 3.1.3. the name of the drug;
- 3.1.4. the drug strength, quantity, and formulation (tablet, liquid, patch);
- 3.1.5. the dose and directions for use;
- 3.1.6. the full date the prescription was issued (day/month/year);
- 3.1.7. refill instructions, including dispensing intervals, if applicable;
- 3.1.8. method to contact the prescriber - telephone number[5], email address, or facsimile number.

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[3] Limited exceptions are:

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

[4] Paper prescriptions handed to the patient must be signed in ink by the prescriber. Electronically transmitted prescriptions may be signed electronically. Rubber stamped signatures are not permitted.

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

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

3.3. If the prescriber is an Associate Registrant (Clinical Assistant, Physician Assistant, or Resident). see the Practice Direction on Prescribing by Clinical Assistants and Physician Assistants. Residents must include the same contents as Section 9 of that Practice Direction.

4. Format of Prescriptions including Verbal

4.1. Prescriptions may be handwritten (legibly), electronically generated in accordance with the Practice Direction on Electronic Transmission of Prescriptions, verbally relayed, or in the physician's order sheet in a hospital, PCH, or residential healthcare institution as per section 10 of this Standard.

4.2. Verbal prescriptions for all drugs must include all the information included in s.2.1 above other than the signature and prescription issue date. The prescriber may delegate verbal prescription renewals to an agent, but the prescriber assumes responsibility for that agent's actions. The agent must identify themselves and the prescriber must be available in a reasonable time frame to speak to the pharmacist if requested to do so.

4.3. Verbal prescriptions are permitted for all drugs and substances, subject to section 6 of this Standard and any institutional policies.

5. Sample Medication- [Still to be discussed by Working Group: Starter packs (Rural Remote Underserved PD]

5.1. A registrant must:

5.1.1. keep sample medication in a secure location;
5.1.2. dispose of sample medication in a safe and environmentally acceptable manner;
5.1.3. not offer to sell or barter sample medication for any purpose whatsoever; and
5.1.4. not have any form of material gain from distributing the sample medication.

5.2. A registrant must ensure if a sample drug is provided to the patient it is provided with clear instructions for its use, including any precautions, and it is not expired.

6. Direct Patient Contact

6.1 Prescribing medication or counter-signing a prescription without direct patient contact does not meet an acceptable standard of care. Subject to subsection (2), there is no

direct patient contact when the registrant relies upon a mailed, faxed or an electronic medical questionnaire.

6.2 An exception to the requirement for direct patient contact exists for registrants who:
- 6.2.1 are fulfilling responsibility as part of a call group;
- 6.2.2 treat their own patients after normal office hours;
- 6.2.3 are in an academic teaching environment;
- 6.2.4 are providing Naloxone as part of a harm reduction strategy for substance abuse.

6.3 In order to meet an acceptable standard of practice, the registrant must demonstrate that there has been:
- 6.3.1 a documented patient evaluation by the Manitoba registrant signing the prescription, including history and physical examination, adequate to establish the diagnosis for which the drug is being prescribed and identify underlying conditions and contra-indications;
- 6.3.2 sufficient direct dialogue between the Manitoba registrant and patient regarding treatment options and the risks and benefits of treatment(s);
- 6.3.3 a review of the course and efficacy of treatment to assess therapeutic outcome, and
- 6.3.4 maintenance of a contemporaneous medical record that is easily available to the Manitoba registrant, the patient, and the patient's other health care professionals.

7. Manitoba Prescribing Practices Program (M3P Drugs)

7.1. Prescribers (including physicians and clinical assistants/ physician assistants in accordance with the Practice Direction on Clinical Assistant and Physician Assistant Prescribing) must prescribe the drugs listed on the attached M3P schedule in the manner prescribed in the Regulation and this Standard.

7.2. Section 6 of this Standard does not apply to:
- 7.2.1. prescriptions for drugs administered in a personal care home as described under the Manitoba Health Services Insurance Act,
- 7.2.2. prescriptions for drugs administered in a hospital or institutional residential healthcare facility,
- 7.2.3. the direct administration of a designated drug to a patient by a prescriber.

7.3. All prescription drugs on the attached Schedule must be written on a prescription form as is approved by CPSM. This requirement for a written form is exempt from verbal prescribing under section 7.8. *[The form is still to be discussed by the working group]*

7.4. The treatment goal and/or diagnosis and/or clinical indication(s) must be included for all M3P prescriptions.

7.5. The prescription must contain only one drug per prescription form.

7.6. The prescription is only valid for three days after its issuance to the patient and the physician must so advise the patient.

7.7. Prescribers must prescribe in accordance with the Practice Direction for Prescribing Methadone or Buprenorphine/Naloxone.

7.8. If verbal prescribing for M3P medications the prescriber must:

7.8.1. notify the pharmacist the verbal order is required as timely access to fax or electronic transmission is not possible **and** the medication is urgently required by a Manitoba patient.

7.8.2. clearly communicate the verbal order directly to the pharmacist[6], including all the information on the M3P form required for an M3P prescription.

7.8.3. ask the pharmacist to repeat back all contents of the prescription required in section 3 (Contents of Prescription) to ensure accuracy and patient safety.

7.8.4. fax or electronically transmit the same M3P prescription which was provided via a verbal order to the pharmacist. This must be done as soon as reasonably possible.

7.8.5. indicate the following on the faxed electronic prescription "This prescription was previously provided as a verbal order".

7.8.6. verbal prescribing of M3P drugs is to be **used sparingly, in very limited circumstances when timely fax or electronic transmission of a prescription is not possible <u>and</u> may otherwise lead to a delay in access to urgently needed medication for a patient.** This is not to be used as a routine workaround to the usual M3P process.

8. Dispensing Physician (Note – determine if utilized currently – there is only one example CPSM can locate from many years ago)

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

8.2. A registrant may dispense or sell a drug or vaccine only if the registrant is authorized to do so under The Pharmaceutical Act and in compliance with the requirements of that Act and regulations made thereunder.

[6] This requirement cannot be sufficiently satisfied by a prescriber leaving a voice message. If a voice message is left by a prescriber, a direct callback number must be included to facilitate the pharmacist calling back and verifying the verbal order directly with the prescriber. A verbal order is not considered valid until a pharmacist speaks directly with the prescriber to verify the order. There can be no delegation to an agent.

9. Additional Information for Prescribers

9.1. The prescriber is reminded in particular of the following:

9.1.1. Prescription Drugs (included on Health Canada's Prescription Drug List) - the number of repeats must be noted by the prescriber as the pharmacist has no discretion under Federal legislation.

9.1.2. Controlled Drugs - Under Federal legislation the number of part-fills and the intervals between part-fills must be specified in the prescription.

9.1.3. Narcotic Prescriptions cannot be refilled (part-fills may be permitted). New signed prescriptions must be in the hands of the pharmacist on each occasion where a narcotic is dispensed (or telephoned in the case of verbal prescription narcotics).

9.1.4. Prescription quantities should be related to the timing between follow-up visits.

9.1.5. The prescriber is required to maintain a record of all prescriptions written and authorized, including refills.

Part B - Prescribing in a Hospital, PCH, Residential Health Care Institution ("Orders")

10. Sections 10 and 11 apply to prescribing of drugs that are administered:

- In a personal care home as described under the Manitoba Health Services Insurance Act,
- In a hospital or institutional residential health care facility;
- Via the direct administration of a designated drug to a patient by a prescriber.

Notwithstanding the above, in these facilities prescribers must only do the following:

10.1. Content of Prescription Orders:

10.1.1. the name of the drug;

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

10.1.3. the dose and directions for use;

10.1.4. the full date and time that the prescription was issued (day/month/year)

11. Before Prescribing in a Hospital, PCH, Residential Health Care Institution

11.1. 1 Prescribers must only prescribe a drug if they have the knowledge, skill, and judgment to do so safely and effectively.

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

11.2.1. document in the patient's medical record a diagnosis or differential diagnosis and/or a clinical indication for the drug prescribed based on the clinical assessment and any other relevant information (as reasonably appropriate);

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

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

11.3. If the prescriber is an Associate Registrant (Clinical Assistant, Physician Assistant, or Resident). see the Practice Direction on Prescribing by Clinical Assistants and Physician Assistants. Residents must include the same contents as Section 9 of that Practice Direction.

PRACTICE DIRECTION

Prescribing Drugs and Vaccines by Clinical and Physician Assistants

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

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

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

DRAFT

1. PREAMBLE

1.1. Clinical Assistants (CAs) and Physician Assistants (PAs) are registered by CPSM as qualified medical practitioners engaged in the practice of medicine in Manitoba.

1.2. CAs and PAs practice under a contract of supervision which provides a practice description outlining the duties and services they will provide. *CPSM General Regulation* s. 8.3 and 8.6. This includes their individual prescribing powers.

1.3. Prescribe is defined as "to issue a prescription for a dental appliance, drug, vaccine, vision appliance, or wearable hearing instrument." *RHPA* s. 3

1.4. Prescription is defined as "in respect of a drug or vaccine, a direction to dispense a stated amount of a drug or vaccine specified in the direction of the individual named in the direction." RHPA, s. 3

1.5. Prescribe and Prescription includes both prescriptions in the community and what are commonly called "orders" in hospitals and health care institutions.

2. PRESCRIBING ABILITIES

2.1. As a regulated class, CAs and PAs have the authority to perform the reserved act of prescribing a drug or vaccine only if:

2.1.1. their supervisor has determined the assistant is qualified to prescribe that drug or vaccine; and

2.1.2. the prescribing is done in accordance with the assistant's practice description. *CPSM General Regulation*, s. 5.12(1).

2.2. The prescribing practice of a CA or PA must be within the scope of practice of their supervising physician.

2.3. As a regulated class of medical practitioners, CAs and PAs have the authority to prescribe all drugs and vaccines listed under the federal *Food and Drugs Act*, *Controlled Drugs and Substances Act* and regulations, subject to their individual contract of supervision.

2.4. This authority to prescribe extends to all patients located in Manitoba, whether the patient is in the community, a hospital or healthcare institution, whether provincial or federal. This authority also includes a patient that is located in a First Nations community, hospital, nursing station or health care institution in Manitoba.

3. PRESCRIPTION CONTENTS

3.1. A prescription issued by a physician assistant or a clinical assistant must include

3.1.1. their name and the designation "PA" or "Cl. A", as the case may be;

3.1.2. the name of their supervising physician;

3.1.3. the CA's or PA's telephone or paging number; and

3.1.4. one or more of the following:

3.1.4.a. the patient's clinical indication,

3.1.4.b. the patient's diagnosis,

3.1.4.c. the treatment goal for the patient. *CPSM General Regulation*, s. 5.12(2)

3.1.5. CPSM registration number of CA or PA (Note: subject to these being issued by Manitoba Health).

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 22, 2023
BRIEFING NOTE

SUBJECT: Physician Health Program Presentation

RECOMMENDATION:

That Council receive this presentation, which will be provided at the meeting, for information.

KEY MESSAGE:

The Physician Health Program is an important part of CPSM's Department of Quality. Their work in helping the increasing numbers of registrants who are struggling with acute or chronic health issues. It supports the CPSM mandate to protect the public and monitor the profession and ensure their fitness to practice medicine.

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

Registrants have the same physical and mental health issues as the general population. However, there has been a culture of silence which has hindered registrants seeking help. Registrants practice in a high stress, high risk profession. If registrants are addressing their physical and mental health issues alone and in silence, there is a significant risk to patients who are relying upon them for professional services. Providing a safe, confidential and non-disciplinary structured program to help registrants address their health issues reduces the risk to patients who are relying upon registrants for medical services. Enabling registrants to address their health issues also assists them to remain practicing which they might otherwise have to leave if their health issues are not addressed.

The College of Physicians & Surgeons of Manitoba

Physician Health Program

Presentation by:
Dr. Ainslie Mihalchuk, Assistant Registrar - Quality

CPSM protects the public and promotes the safe and ethical delivery of quality medical care by physicians in Manitoba.

CPSM and Regulation

Legislated by the Manitoba government through the ***Regulated Health Professions Act.***

"Must engage in practice of medicine competently and with decency, integrity and honesty and in accordance with the law."

Regulation must **serve and protect the public** interest.

Self-Regulation is a privilege, and it comes with the **professional responsibility** to practice in a safe, ethical, and competent manner.

Physician Health Program

Dr. Ainslie Mihalchuk, MD CCFP FCFP
Assistant Registrar – Quality

Dr. Alewyn Vorster, MBChB CCFP
Director of PHP (appointed by Registrar)

Kim Parks
PHP Coordinator

Physician Health Program goal

CPSM **must ensure registrants are safe to practice** in the interest of patient safety.

Physician Health Program provides **compassionate and collaborative support** for registrants facing acute or chronic health issues.

Goal is to enable registrants to **maintain practice or return to practice** as soon as they are safe to do so.

Duty to Report

Registrants have a **duty to report** when they have a **medical condition** that may impair their ability to practice medicine safely.

Registrants also have a **duty to report a colleague** if there is a concern about **safety to practice.**

Safe & Confidential

Physicians who experience illness are often reluctant to report because of **fear.**

Reporting has to be SAFE

Physician Health Program is **confidential**, **non-disciplinary** and focused on ***rehabilitation, recovery and ultimately the registrant's success.***

2023 Program Stats (2022-23 Year-to-date)

*** with 8 weeks left until year-end***

83 New Referrals

4 New Undertakings
(out of the new 83 referrals)

SELF-REFERRALS

TOTAL
30
(TO-DATE)

INCREASE OF
25%
OVER LAST YEAR

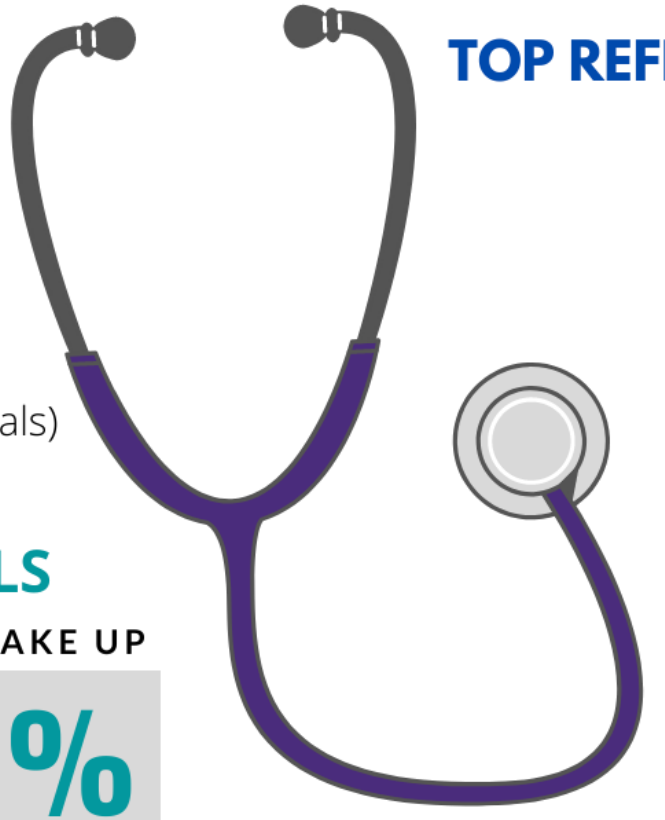
TOP REFERRAL CATEGORIES:

- **Mental Health**
- **Burnout/Stress**
- **Cancer**

2022 Program Stats (May 1, 2021 – April 30, 2022)

84 New Referrals

4 New Undertakings
(out of the new 84 referrals)



SELF-REFERRALS

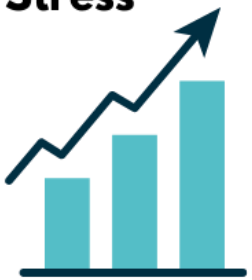
INCREASED BY	AND MAKE UP
50%	**29%**
OVER LAST YEAR	OF ALL REFERRALS

TOP REFERRAL CATEGORIES

19%
Anxiety & depression
including major depressive episodes

11%
Burnout & Stress

12%
Cancer



From May 1, 2021- April 30, 2022

Scenario 1

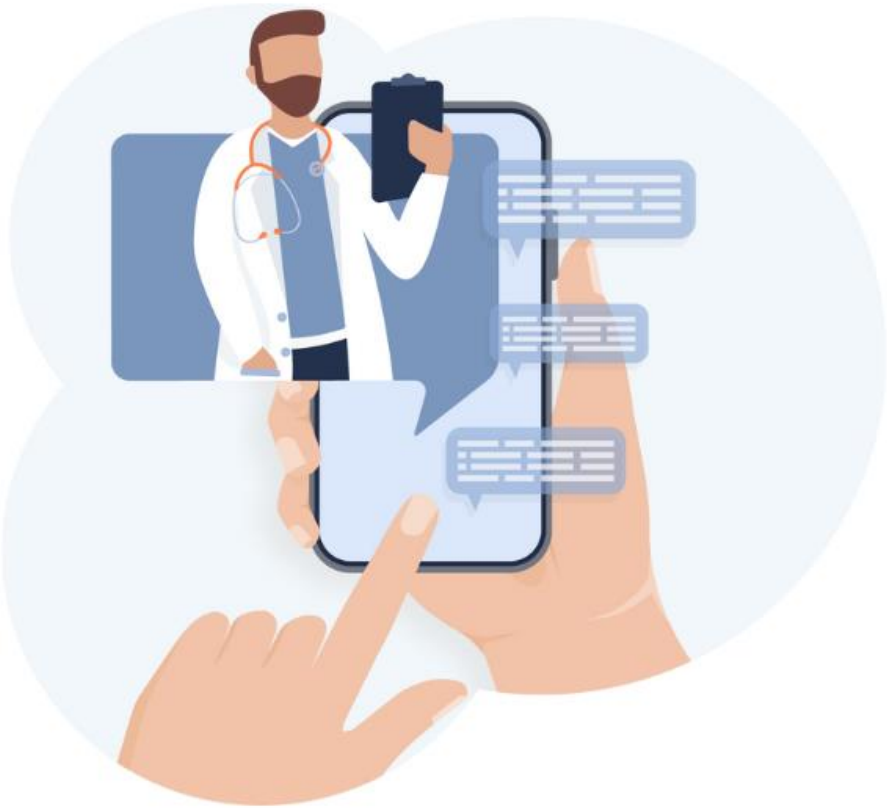
Doctor A self-reports a mental health condition (either on their registration renewal; or by contacting the PHP email/phone number).

- What happens next?

Scenario 2

Doctor B is reported by their own doctor/colleague for a medical condition causing impairment.

- Doctor B also contacts CPSM
- Doctor B does not self-report

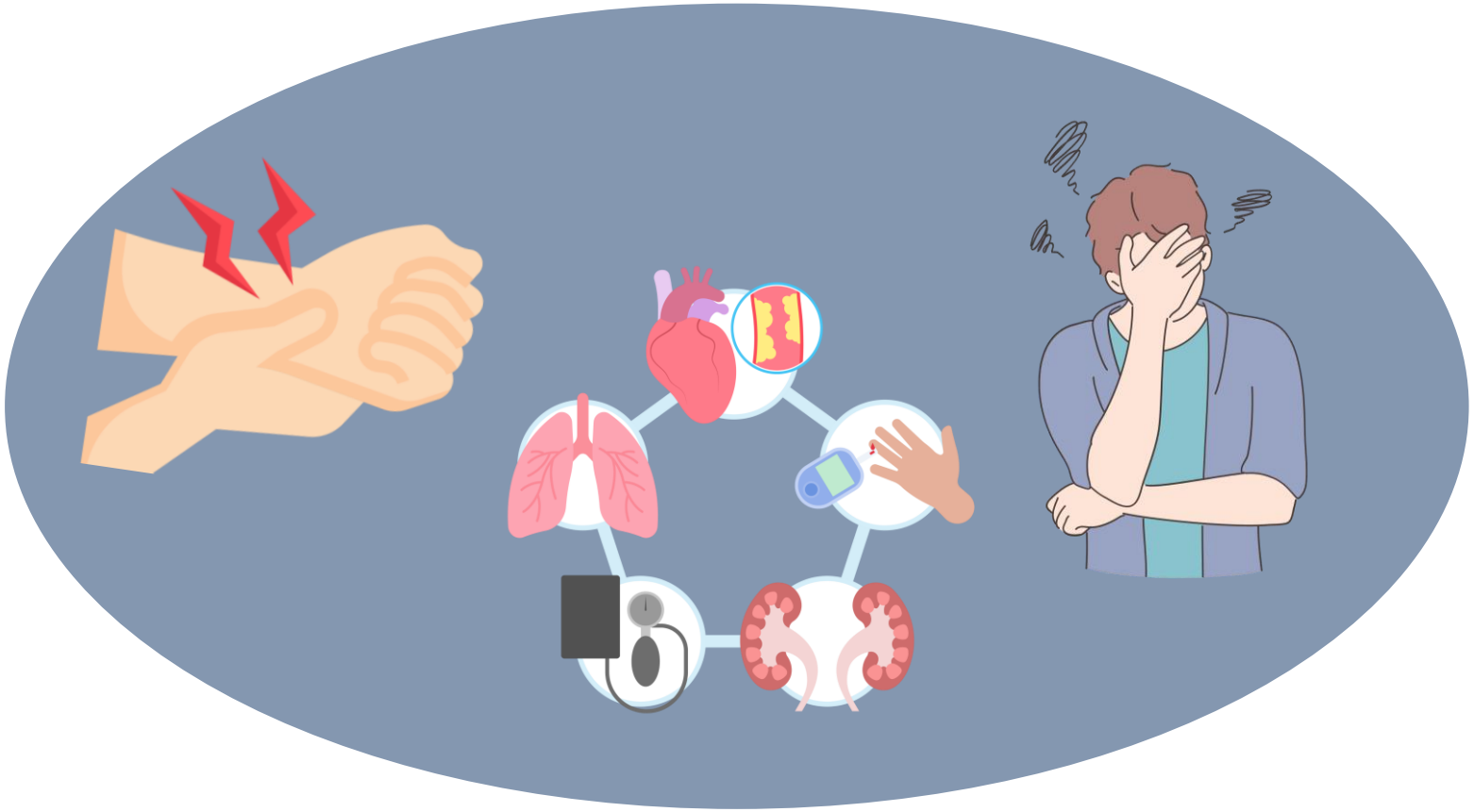


Scenario 3

Doctor C has a very serious medical condition and CPSM PHP is made aware.

- Obvious evidence of impairment
- Unclear if the doctor is impaired in practice or if there is significant potential for impairment in practice

When to Report a Condition



Any health condition –physical or mental – with the **potential to impact the ability to provide safe and competent care.**

Reportable Health Conditions

0083

The College of Physicians & Surgeons of Manitoba

Examples of
reportable health conditions:

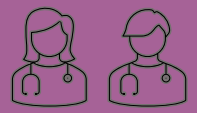
- *substance use disorder*
- ***c**ancer*
- *chronic pain*
- *mental illness*
- *neurological conditions (e.g. stroke, multiple sclerosis, Parkinson's)*
- *blood borne pathogens*

Leaves of Absence are reportable

Report early

The PHP approach

Every referral is handled with compassion, discretion, and a personal connection



Assistant Registrar and Director have a joint decision-making role

Seek input from care providers and independent medical assessments where appropriate

Ensure patient safety while supporting registrants

Goal is to keep members working or return to practice as soon as they are safe to do so

How does PHP help registrants?

Care Connecting

Support & Encouragement

Guidance for practice environment to support optimal well being

Formal agreements

How does PHP help registrants?

The Physician Health Program **does NOT** have the authority to remove a certificate of practice (license).

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 22, 2023
NOTICE OF MOTION

SUBJECT: **Registration Policies and Practice Directions**

BACKGROUND:

Council has chosen as a Strategic Organizational Priority to review and update all Standards of Practice, Practice Directions, and Council Policies.

CPSM staff are reviewing Council Policies, Registrar's Policies, and Practice Directions that predominantly relate to activities carried out through CPSM's Registration Department, including the following Practice Directions:

- Cancellation of Registration or Certificate of Practice Pursuant to S 48 of the RHPA,
- Decisions Regarding Permits for Health Profession Corporations & Related Appeals,
- Manitoba Practice Assessment Program Summative Assessment,
- Qualifications and Registration,
- Reinstatement Application, and
- Medical Corporations and Clinic Names.

The goal of this project is to revise and update these documents, and then compile and organize them into a single source to be referred to in future as CPSM's Registration Policies and Practice Directions. This will be an indexed and easy to navigate document that supports transparency and accessibility regarding CPSM's registration requirements. This motion is an important step in that process.

The first three documents to be considered by Council relate to the Provisional (MPAP) Class, the Assessment Candidate (Re-Entry) Class, and scope of professional practice and inactivity more broadly. These documents are considered together as they address overlapping issues, including how CPSM looks at registrants' professional practice from a registration and qualifications perspective.

Practice Direction vs. Policy

Practice Directions are rules for registrants in practice (see sections 85 and 86 of the RHPA) and have special meaning under multiple provisions of the RHPA. Registrants of CPSM are legally required to comply with Practice Directions issued by Council. The *Affairs of the College Bylaw* includes:

> *83(d) Before making a new Practice Direction, the Registrar must:*
> *a. post on CPSM website an explanation of the proposed change,*
> *b. and, within a specified time frame of at least 30 days, seek the input of registrants and any other person Council considers necessary on the proposed change; and*

c. present Council with the results of consultation for consideration before it votes on the proposed Practice Direction.

While registrants are expected to comply with CPSM policies, these are less formal and are generally implemented to control internal operations and procedures. The *Affairs of the College Bylaw* obligates officers of CPSM to comply with Council Policies. In carrying out CPSM's mandate, staff are to follow policies of the Registrar and Council. Policies do not require a public consultation process. They can be used implement sections of the *CPSM General Regulation* that require approval by Council or the Registrar. Section 1.4 (Definitions) of the *CPSM General Regulation* includes:

***"approved"** means approved by the council except where the approval is indicated to be given by the registrar or other person or body.*

Council Policy - Manitoba Practice Assessment Program ("MPAP"):

MPAP is an additional route to full practicing class registration. The purpose of MPAP is to provide an assessment of the clinical practice of provisional registrants. Current eligibility requirements include:

- Registrants must attempt all examinations they are eligible to write:
  - o MCCQEI
  - o Royal College of Physicians and Surgeons of Canada Certification Examination OR College of Family Physicians of Canada Certification Examination.
- Must be currently registered with CPSM and actively practising in Manitoba on the Provisional Register – minimum 2 years.
- Must be referred by CPSM to University of Manitoba, Division of Continuing Professional Development.
- Must be admitted and registered by the University.
- Duration from date of referral to completion of assessment is 8 – 10 months.

The rules for MPAP are currently in a stand-alone MPAP Practice Direction.

By this motion, Council is asked to repeal the current MPAP Practice Direction and replace it with a new MPAP Council Policy. Here is the link to the current MPAP Summative Assessment document that Council is being asked to repeal:

- http://cpsm.mb.ca/assets/Practice%20Directions/Manitoba%20MPAP%20Summative%20Assessment.pdf

The proposed replacement is presented as a Council policy as it implements various features of the *CPSM General Regulation* that require Council approval. However, the document does not need to be a Practice Direction as the various rules that apply in this context are either addressed through the *CPSM General Regulation* or in standard form undertakings that are used in the application process. This Council Policy, if approved, will replace the current MPAP Practice Direction. Significant changes:

- Applicants are no longer required to have attempted the LMCC examination (i.e., MCCQE1).
- The Provisional (Academic - S. 181 Faculty) Class is expressly included, as contemplated by the *CPSM General Regulation*.
- Enhanced details respecting determining scope of assessment and professional practice.
- Improved explanation of two years of continuous practice requirement.
- Clearer timelines and explanation of potential outcomes.
- Addresses impact of Manitoba Faculty appeal proceedings.

Otherwise, the substance of the MPAP Practice Direction is largely carried forward.

Practice Direction – Professional Practice and Inactivity

In instances where a registrant has been away from their practice for three years or longer, the Registrar must assess their ability to provide safe, competent care before they can issue registration. An inactive physician is defined as *a physician who is planning to re-enter practice after being on leave for three years or more, whether it is a general absence from all clinical activity or a specific absence from one or more fields of clinical practice through restriction of practice or through practice in a specific setting.*

A physician who has not practiced within a scope of practice for three years or longer is also considered to be inactive in that scope.

In many ways, this proposed Practice Direction supports and facilitates the concurrently proposed 'Council Policy - Manitoba Practice Assessment Program and the 'Council Policy – Assessment Candidate (Re-Entry to Practice) Class' (see below). It is also intended to assist registrants in understanding appropriate professional practice boundaries and the concept of inactivity versus evolution of practice. It is presented as a Practice Direction as it clarifies several professional expectations concerning which registrants will need to comply if it comes into force, and requires specified steps be taken when considering expanding one's professional practice into an area of inactivity. Key features include:

- Defines inactivity and clarifies how CPSM views active scopes of practice.
- Brings together various professional expectations that apply to maintaining a safe and competent practice.
- Expressly states registrants cannot enter an area of inactivity without CPSM approval.
- Provides factors to consider when determining if a registrant is entering an area of inactivity.
- Updates language respecting family physicians who wish to include obstetrics or anaesthesia in their professional practice.

This new Practice Direction will replace Parts 2.4 to 2.6 of the 'Registration and Qualifications Practice Direction'. Here is the link to this current Practice Direction:

- http://cpsm.mb.ca/assets/Practice%20Directions/Qualifications%20and%20Registration.pdf

Council Policy – Assessment Candidate (Re-Entry to Practice) Class

Physicians who currently hold registration and wish to change their practice may continue to hold their existing registration while undertaking training in the new area, provided they continue to meet all other requirements. For those who have not engaged in practice for three (3) years, or who wish to change the focus or scope of practise to an area or field in which they have not practiced in the three (3) years immediately preceding the application may be registered as an Assessment Candidate (Re-Entry to Practice) Class registrant in order to meet the re-entry to practice requirements. The requirements are:

- provide a written description of the applicant's intended professional practice or change in the focus or area of practice and a re-entry plan in accordance with policies approved by the Council,
- completion of a period of, mentorship with a practice mentor or supervision with a practice supervisor, and
- successful completion of any examinations, tests, assessments, training, or education approved by the Registrar in accordance with Council policies that the Registrar considers necessary to determine that the member is competent to engage in professional practice.

The re-entry class is only available to those who meet all the criteria for registration except the minimum practice requirement in one of the following classes:

- Full (Practicing),
- Provisional (Academic — s. 181 Faculty),
- Provisional (Specialty Limited), and
- Provisional (Family Practice Limited).

A physician who is registered in one of the classes in the previous paragraph and wishes to change the focus or area of practice to a focus or area in which he or she has not practiced within three years immediately before the application date may continue to be registered in their current membership class while they undergo a review and assessment.

This is presented as a Council Policy as it implements various features of the *CPSM General Regulation* that require Council approval. It does not need to be a Practice Direction as the various rules that apply in this context are either addressed through the *CPSM General Regulation,* the 'Practice Direction – Professional Practice and Inactivity', or in standard form undertakings used in the application process. Key features include:

- Better description of process.
- Brings together various requirements from different areas of the *CPSM General Regulation*.
- Greater detail about what is required for a re-entry plan.

This Council Policy, if approved, will replace Part 2.3 of the 'Registration and Qualifications Practice Direction'. Here is the link to this current Practice Direction:

- http://cpsm.mb.ca/assets/Practice%20Directions/Qualifications%20and%20Registration.pdf

Several other MRAs (including Ontario and BC) have introduced requirements respecting registrant's changing their scope of professional 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.

CPSM strives to maintain clear and publicly available requirements for registration. Most importantly for patient safety, Registration ensures that at point of initial registration in that particular class, registrants hold the correct requirements to be registered to practice medicine in Manitoba.

CPSM frequently receives questions from registrants about the rules surrounding re-entry to practice or changing their professional practice. Having clear guidance and a process established to respond to these inquires serves the public interest.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 22, 2023, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves:

A) repealing the current MPAP Practice Direction and replacing it with Council Policy – Manitoba Practice Assessment Program as attached, to be effective immediately.

B) the attached Practice Direction – Professional Practice and Inactivity be distributed to the public, stakeholders, and registrants for consultation.

C) amending Practice Direction – Qualifications and Registration by deleting Part 2.3 and approves the new Council Policy – Assessment Candidate (Re-Entry to Practice) Class as attached, to be effective immediately.

Attachments:

- New Council Policy - Manitoba Practice Assessment Program
- New Practice Direction - Professional Practice and Inactivity
- New Council Policy – Assessment Candidate (Re-entry to Practice) Class

COUNCIL POLICY - DRAFT
The Manitoba Practice Assessment Program ("MPAP")

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

PURPOSE

The purpose of the Manitoba Practice Assessment Program ("MPAP")[1] is to provide a means by which a participant is assessed to determine whether they are competent to engage independently in the practice of medicine in one or more fields of practice offered by the program.[2] It is a summative assessment. Successful completion of MPAP in accordance with CPSM requirements is an alternate route to full registration for certain classes of provisional registrants who have not met all the usual criteria at subsection 3.8 of the *CPSM General Regulation* (i.e., certification from the CFPC or from the Royal College).

MPAP is administered by Clinician Assessment Programs through the Max Rady College of Medicine in the Rady Faculty of Health Sciences at the University of Manitoba ("Manitoba Faculty"). The Manitoba Faculty is independent of CPSM.

[1] See section 1.4 of the *CPSM General Regulation*.
[2] See section 7.2 of the *CPSM General Regulation*.

CONTENTS

1. OVERVIEW OF THE PROCESS FOR PARTICIPATING IN MPAP

To participate in MPAP, provisional registrants of CPSM must:

- apply to CPSM for referral to the Manitoba Faculty to participate in MPAP,
- be admitted and registered in MPAP by the Manitoba Faculty, and
- convert to the Provisional (MPAP) Class of registration while they participate.

If successful in MPAP, then the candidate may be converted to full registration.

2. APPLYING TO CPSM FOR REFERRAL TO MPAP BY THE REGISTRAR

Sections 7.4 and 7.5 of the *CPSM General Regulation* provide as follows:

- *7.4. The registrar may refer an applicant to the MPAP in accordance with [CPSM's] requirements.*

- *7.5. The Manitoba faculty may register an applicant who has been referred to the MPAP in accordance with the faculty's policies.*[3]

An applicant may apply for referral to MPAP by submitting to the Registrar:[4]

- a signed application in the approved form,
- the fees provided for in the bylaws, and
- any other information requested by the Registrar.

Eligibility criteria for referral to MPAP and subsequent registration in the Provisional (MPAP) Class are set out at sections 3.22, 3.23, and 3.24 of the *CPSM General Regulation*. These provisions are described in this Policy.

This Policy describes the information and supporting documentation that will ordinarily be required by the Registrar in the application process and CPSM's requirements (i.e., requirements approved by Council) for participating in MPAP.

3. CPSM'S REQUIREMENTS FOR REFERRAL TO MPAP

CPSM's requirements for referral to MPAP for the purposes of section 7.4 of the *CPSM General Regulation*:

3.1. At the time of referral, the MPAP candidate must meet the eligibility criteria for registration in the Provisional (MPAP) Class, including that they must be registered in one of the following classes:[5]

3.1.1. Provisional (Specialty Practice-Limited) or Provisional (Family Practice-Limited),[6]

3.1.2. Provisional (Academic — S. 181 Faculty),[7] or

[3] Registrant's who apply to MPAP are expected to familiarize themselves with the Manitoba Faculty's policies to ensure compliance with their prerequisites. CPSM has no control over the Manitoba Faculty's admissions policies and practices.

[4] See section 7.3 of the *CPSM General Regulation*.

[5] See subsection 3.22(1) of the *CPSM General Regulation.*

[6] Per subsection 3.22(1)(a), the applicant must hold a certificate issued by the minister stating that the applicant is required to provide medical services in a specified geographical area or practice setting.

[7] Per subsection 3.22(1)(b), an applicant will be eligible if they, "*had been registered in good standing, and had practised continuously, for at least two years as a provisional (academic — s. 181 faculty) member and no more than 60 days has passed since [their] s. 181 certificate was revoked or had lapsed.*"

3.1.3. Provisional (Non-Practising), as applicable under subsection 3.22(1)(d) of the *CPSM General Regulation*.[8]

3.2. Candidates applying for MPAP who are registered in the Provisional (Specialty Practice-Limited) Class, Provisional (Family Practice-Limited) Class, or the Provisional (Non-Practising) Class must submit their application to CPSM for referral to MPAP no later than thirty (30) months before the expiry of their provisional registration.[9]

3.2.1. The Registrar may, in their sole discretion, waive this requirement in exceptional circumstances.

3.2.2. This would not apply to applicants from the Provisional (Academic — S. 181 Faculty) Class (see subsection 3.22(1)(b) of the *CPSM General Regulation*).

3.3. The candidate must complete an application in the form required by CPSM and pay the fee for the documentation review and the referral process.

3.3.1. The fee is intended to cover CPSM's cost of review of the application for referral to MPAP and the movement to full registration if the candidate is successful.

3.3.2. It does not include the cost of the assessment itself, which is to be dealt with by the Manitoba Faculty.

3.4. The candidate must have made all reasonable efforts to obtain certification from the CFPC or the Royal College, if eligible, including by attempting all available examinations.

3.4.1. If a candidate states that they are not eligible for the certification process, then the candidate must produce documentation from the CFPC or the Royal College verifying they are not eligible.

3.5. As part of their application, the candidate must provide a clear description of the scope of assessment which the candidate wishes to have performed. The proposed scope of assessment must meet the following criteria:

3.5.1. For family medicine, the scope of assessment must be structured to demonstrate competence of the candidate and safety to practice in the full spectrum of family medicine care for the patient population

[8] Per subsection 3.22(1)(d), an applicant will be eligible if they are *"registered as a provisional (non-practising) member under subsection 3.34(2) immediately before applying for registration in this class and before being registered in provisional (non-practising) member, [they] had been registered as a member in the provisional (speciality practice-limited), provisional (family practice-limited) or provisional (academic – s.181 faculty) class in good standing, and had continuously practised as such, for at least two years.*"

[9] Registrants in the Provisional (Specialty Practice-Limited) Class, or the Provisional (Family Practice-Limited) Class must be working toward meeting the requirements for full registration. It is expected they will achieve full registration within five (5) years.

proposed[10], subject to the right of the candidate to exclude anaesthesia and/or obstetrics.

3.5.2. For other specialty or sub-specialty fields of practice, the scope of assessment may be for the entire specialty or sub-specialty field or may be a restricted practice to an area or areas within the specialty or sub-specialty field.[11] In either case, the scope of assessment must be structured to demonstrate competence of the candidate and safety to practice in the full spectrum of medical care for the patient population within the entire specialty or sub-specialty field or within the patient population for the restricted area of practice within the specialty or sub-specialty field as the case may be.

3.5.2.1. With respect to speciality or subspecialty restricted areas of practice, the Registrar retains the sole discretion to refuse to refer a candidate on the grounds that the proposed scope of practice is so restricted that successful completion of the assessment will not demonstrate the candidate is able to provide safe and competent medical care.

3.6. Candidates must provide a clear description of the scope of their current professional practice, including the following details:[12]

3.6.1. current practice location(s),

3.6.2. the practice environment, including practice context (e.g., institutional, or non-institutional, available supports and resources, etc.),

3.6.3. volume of practice,

3.6.4. patient population and demographics,

3.6.5. ongoing continuing professional development activities, and

3.6.6. general information about

3.6.6.1. reserved acts and procedures performed,

3.6.6.2. types of diagnoses and differential diagnoses or complications addressed in practice, and

3.6.6.3. treatments and management provided, including prescribing.

3.7. Subject to the applicability of subsections 3.22(1)(b)(ii) or (d) of the *CPSM General Regulation*, the candidate must be currently practicing medicine in Manitoba and must have had at least two (2) years of continuous active practice in Manitoba.

3.7.1. The continuous active practice must be sufficient, in the sole discretion of the Registrar, to allow for appropriate assessment of the candidate to determine whether they are safe and competent to engage

[10] For example, excluding paediatric patients. Notable areas of inclusion or exclusion should be included in the scope of assessment, such as emergency medicine, addictions medicine, etc.

[11] For example, the scope of assessment may be orthopaedic surgery or orthopaedic surgery, limited to diabetic feet)

[12] The form application contains fields where these details are requested. As with the scope of assessment, information regarding notable areas of inclusion or exclusion will be requested.

independently in the practice of medicine in the scope of practice to be assessed by MPAP. This will usually require an established and consistent professional practice in a single practice setting or group of practice settings over the past two-year period.

3.7.2. In exercising their discretion, the Registrar will consider the Manitoba Faculty's policies in this regard and the intended scope of assessment. The Manitoba Faculty may reach a different conclusion on this point when considering an application for admission (see paragraph 4.6, below).

3.8. As a pre-requisite to referral to MPAP, candidates must sign an agreement and undertaking respecting their participation in MPAP in a form satisfactory to the Registrar. This will include a declaration that they will comply with the terms and conditions of MPAP.[13] The agreement and undertaking will include consent for CPSM to release to the Manitoba Faculty:

3.8.1. details about the candidate's current professional practice,

3.8.2. the candidate's description of the scope of assessment, and

3.8.3. the candidate's agreement and undertaking to participate in MPAP as well as the undertaking of their supervisor.

3.9. In considering referral and in determining any appropriate terms and conditions to be imposed respecting the candidate's participation in MPAP, the Registrar will review:

3.9.1. any monitoring, supervision or audit reports obtained as part of the candidate's provisional registration with CPSM, and

3.9.2. the candidate's professional conduct history.

3.9.3. The information to be reviewed described in this paragraph will usually not be shared with the Manitoba Faulty, unless the Registrar deems same relevant to the MPAP process.

4. TERMS AND CONDITIONS FOR PARTICIPATING IN MPAP

Sections 7.6. and 7.7. of the *CPSM General Regulation* provide as follows:

> *7.6 The registrar may impose conditions that the registrar considers necessary or advisable on a participant's certificate of registration or certificate of practice or both at any time during application to, or registration or participation in, the MPAP.*[14]

[13] See subsection 3.22(2) of the *CPSM General Regulation.*

[14] Terms and conditions imposed are usually included as part of the CPSM MPAP agreement and undertaking that candidates are required to sign as part of the application process.

7.7 A participant must comply with the terms and conditions of the MPAP, and any conditions imposed by the registrar.

Subsection 3.22(2) and section 3.23 of the *CPSM General Regulation* provide as follows:[15]

3.22(2) An applicant under subsection (1) must also submit to the registrar a signed declaration that [they] will comply with the terms and conditions of the MPAP and any other conditions imposed by the registrar.

3.23 As a condition of registration, a provisional (MPAP) member must have a practice supervisor and must comply with the terms and conditions of the MPAP and any other conditions imposed by the registrar.

Terms and conditions that are required by the Registrar for the purposes of sections 3.22, 3.23, 7.6 and 7.7 of the *CPSM General Regulation*:

4.1. In addition to applying to CPSM, candidates must complete the application package required by the Manitoba Faculty and supply all the information required by the Manitoba Faculty to permit it to independently determine whether the candidate is eligible for assessment through MPAP.

4.2. If the candidate is accepted into MPAP by the Manitoba Faculty, CPSM will be notified and the candidate will be converted to the Provisional (MPAP) Class of registration, subject to meeting all other CPSM requirements for that class of registration.

4.3. Each candidate's registration and certificate of practice will be made subject to the following terms and conditions during their participation in MPAP:

4.3.1. The candidate must fully cooperate in MPAP, including by complying with all terms and conditions of MPAP established by the Manitoba Faculty, and complete all requirements of MPAP within the time limits set by the Manitoba Faculty.

4.3.2. Registration in the Provisional (MPAP) Class will be revoked if the candidate is dismissed from MPAP. Dismissal from the MPAP is within the sole discretion of the Manitoba Faculty and, amongst other reasons, the candidate may be dismissed for:

4.3.2.1. failure or refusal to complete any requirements of MPAP or failure to comply with any terms and conditions of MPAP, or

4.3.2.2. failure to adhere to specified time limits.

4.4. Candidates are expected to complete required steps in the MPAP process in a timely fashion. This includes strict compliance with time limits set by the Manitoba

[15] The requirements of section 3.22 and 3.23 will usually be included as part of the CPSM MPAP agreement and undertaking.

Faculty. Absent exceptional circumstances, the maximum period in which a candidate may be registered in the Provisional (MPAP) Class will be two (2) years.

4.4.1. Notwithstanding the foregoing, those who are designated partially successful (see below) will generally have a maximum of eighteen (18) months from the date of notification of that designation after which their registration in the Provisional (MPAP) Class expires.

4.5. The candidate must submit required documentation to the Manitoba Faculty no later than twenty-four (24) months before the assessment, or such lesser time as the Manitoba Faculty may approve.

4.5.1. The Manitoba Faculty, in its sole discretion, may waive the twenty-four (24) month requirement.

4.6. The Manitoba Faculty will determine whether the candidate has sufficient data about their practice to complete the assessment. It is understood by CPSM that this requires a qualitative and quantitative review of the applicant's professional practice in Manitoba, including over the required minimum two (2) years of continuous active practice.

4.6.1. This review is independent of CPSM's role in the process and is at the sole discretion of the Manitoba Faculty.

4.7. The candidate must pay the fee assessed by the Manitoba Faculty for the assessment. The cost of the assessment will be set by the Manitoba Faculty and paid by the candidate directly to the Manitoba Faculty.

4.8. The candidate must participate in the assessment within the time frame and in compliance with the requirements and policies fixed by the Manitoba Faculty. CPSM will have no role in the actual assessment, or any appeal process afforded by the Manitoba Faculty.

4.9. Upon completion of MPAP, the candidate must agree that, if successful in MPAP, their registration and certificate of practice will be subject to terms and conditions which restrict their practice commensurate with the scope of the assessment performed, and that variance of the terms and conditions in the future will be subject to the requirements of re-entry of inactive registrants.

4.10. The Registrar is responsible to review the question of whether additional terms and conditions are required to protect the public while the candidate participates in MPAP, or thereafter following successful completion.

5. MPAP OUTCOMES

Section 7.8 of the *CPSM General Regulation* describes the three possible outcomes of MPAP:

> *7.8 After completing the practice assessment under the MPAP, a participant may receive one of the following designations:*
> *(a) "successful in the MPAP";*
> *(b) "partially successful in the MPAP";*
> *(c) "unsuccessful in the MPAP".*

MPAP outcomes are reported to CPSM by the Manitoba Faculty.

6. REPORT FROM THE MANITOBA FACULTY

6.1. The Manitoba Faculty is responsible to prepare a written report respecting a candidate's participation in the assessment process. The report must confirm the field and area(s) of practice assessed and include a classification of the candidate in one of the following categories:

6.1.1. Successful - By this designation, the report of the Manitoba Faculty confirms that a candidate is suitable for safe and competent independent practice within the scope of practice in which the candidate was assessed.

6.1.2. Partially Successful - By this designation, the report of the Manitoba Faculty confirms that the candidate is suitable for safe and competent independent practice within specified components of the scope of practice assessed and is a suitable candidate for remediation and reassessment within the MPAP framework in the remaining components. For candidates designated partially successful, the report will include:

6.1.2.1. Specifics about the required remediation and a remediation plan for the candidate that can be completed within no more than a six (6) month period. [16]

6.1.2.2. The Manitoba Faculty's opinion as to the degree of supervision required by the candidate in order to practice safely while undergoing remediation, if remediation is pursued, and any other terms or conditions that should be imposed on the candidate's ability to engages in the practice medicine during the remediation period.

6.1.3. Unsuccessful - By this designation, the Manitoba Faculty confirms that the candidate would not be appropriately classified as partially successful and

[16] The Manitoba Faculty is not responsible to provide recommended remediation. MPAP is designed for assessment. It is not intended to provide significant additional training and education. Those requiring more than a six (6) month period of remediation are not suitable for reassessment with the MPAP framework.

is not suitable for independent practice within the scope of practice in which the candidate was assessed.

6.2. The Manitoba Faculty will provide CPSM with a letter stating the outcome for candidates who are successful or unsuccessful, like a final in-training evaluation. CPSM will generally regard the letter as sufficient for its purposes.

6.2.1. For successful candidates, the letter will confirm the field and area(s) of practice assessed, highlighting any significant inclusions or exclusions arising from the scope of the assessment, or areas of special interest as applicable.

6.2.2. The Manitoba Faculty will only provide a copy of the written report upon the written request by CPSM for candidates who are successful or unsuccessful.

6.2.3. For the candidates who are partially successful, CPSM will request the full report to assess the candidate's ability to practice safely while undergoing remediation, if remediation is pursued (see below).

7. SUCCESSFUL COMPLETION

Section 7.9 of the *CPSM General Regulation* provides that, *"If a participant receives the designation "successful in the MPAP", then section 3.75 applies.* Section 3.75 provides as follows:

> *3.75 Upon receiving a designation of "successful in the MPAP" or otherwise completing the requirements for full (practising) membership under section 3.8, a member's registration in … (c) the provisional (MPAP) class; … … may be changed by the registrar to the full (practising) class.*

Upon receipt of notice from the Manitoba Faculty that a candidate has received a "successful" designation, the Registrar will convert the candidate's registration to full registration, subject to any exclusions, inclusions, or terms and conditions based upon the scope of the assessment and to any other terms and conditions required in the specific case. The cost of this conversion between classes is included in the initial application fee.

8. PARTIALLY SUCCESSFUL COMPLETION

Sections 7.10 to 7.11 of the *CPSM General Regulation* provide as follows:

> *7.10 If a participant receives the designation of "partially successful in the MPAP", [they] may undergo remediation and reassessment, including participating in a specified course of studies by way of remedial training, in accordance with the college's requirements and the Manitoba faculty policies.*

7.11(1) As an alternative to section 7.10, a participant who receives the designation of "partially successful in the MPAP" may request that conditions be imposed on [their] certificate of registration in the full (practising) class so as to include in [their] professional practice only those area or areas in which the participant was successfully assessed.

7.11(2) The registrar may grant the request if the participant's remaining area or areas within the scope of [their] professional practice are sufficiently broad so as to permit the participant to independently engage in the practice of medicine in a safe and effective manner, and subsection 3.76 then applies.

Upon receipt of notice that a candidate has received a designation of partially successful, CPSM will notify the candidate that they have the option of participating in a remediation plan in accordance with CPSM's requirements for remediation, or, alternatively, that they may request a restricted practice in accordance with section 7.11 of the *CPSM General Regulation*.

If a candidate obtains a "partially successful" outcome and is approved to continue practice while undergoing remediation, full particulars of the assessment results and the required remediation must be provided to:[17]

- the candidate's practice supervisor,
- the Chief Medical Officer of any Regional Health Authority where the candidate has privileges, and
- such other registrants who work with the candidate as the Registrar, acting reasonably, believes must be notified in order to protect the public interest.

9. PARTIALLY SUCCESSFUL CANDIDATES PURSUING THE REMEDIATION ROUTE

CPSM's requirements for partially successful candidates pursuing remediation are as follows for the purposes of section 7.10 of the *CPSM General Regulation*:

9.1. The candidate must complete the remediation plan provided by the Manitoba Faculty. The remediation plan must be capable of completion within six (6) months. Any candidate who requires longer than six (6) months may be a candidate for retraining[18] but will not be permitted to participate in the remediation option within the MPAP framework.

9.2. The candidate must fully cooperate in the remediation process and complete all aspects of the remediation plan within the time frame specified within the remediation plan provided by the Manitoba Faculty.

[17] This is to be acknowledged in the standard form undertaking.
[18] For example, this would be education and training through a residency program See section 7.13 of the *CPSM General Regulation*.

9.3. The candidate will be solely responsible for all costs associated with remediation.

9.4. If the candidate successfully completes the remediation plan, the candidate must participate in a reassessment process, limited to the areas which were the subject of the remediation, within the time frame specified by the Manitoba Faculty. The candidate must pay all costs associated with a reassessment, as determined by the Manitoba Faculty.[19]

9.5. The candidate must comply with all terms and conditions, including for supervision, recommended by the Manitoba Faculty, and any additional terms and conditions required by the Registrar.

9.6. The candidate will be solely responsible for arranging supervision satisfactory to CPSM, and the candidate will be solely responsible for the cost of the supervision.

9.7. If the candidate does not successfully complete the remediation plan or does not successfully complete the reassessment following the remediation, then they shall be deemed unsuccessful in MPAP, with the exception that the Registrar retains discretion to permit the candidate to request a restricted practice in accordance with section 7.11 of the *CPSM General Regulation*.

10. PARTIALLY SUCCESSFUL CANDIDATES ACCEPTING A RESTRICTED PRACTICE

A candidate who has received a partially successful designation may request additional restrictions on their practice to exclude from their practice the areas where remediation is required in accordance with section 7.11 of the *CPSM General Regulation*. Section 3.76 of the *CPSM General Regulation* provides:

> *3.76 Upon receiving a designation of "partially successful in the MPAP", a member's registration in … (c) the provisional (MPAP) class; … … may be changed by the registrar to the full (practising) class in accordance with section 7.11 (restricted professional practice).*

When such a request is made, the Registrar will obtain a complete copy of the report from the Manitoba Faculty to assess whether the candidate is able to deliver safe and competent medical care within the further limited scope of practice.

If, in their discretion, the Registrar is satisfied that the candidate can provide safe and competent medical care within the further limited scope of practice, CPSM will issue full registration and certificate of practice to the candidate, subject to the inclusions, exclusions, or terms and conditions commensurate with the further limited scope of practice.

[19] For partially successful candidates, development of the remediation plan, completion of the plan, and reassessment should all occur in a period of no longer than eighteen (18) months.

11. UNSUCCESSFUL COMPLETION OF MPAP

Section 7.12 of the *CPSM General Regulation* provides:

> *7.12 If a participant receives the designation "unsuccessful in the MPAP", then section 3.85 applies, and the participant's registration is cancelled.*

Upon receipt of notice that a candidate has received an "unsuccessful" designation, the CPSM will cancel the candidate's registration and certificate of practice.

Registrants who are required by CPSM to cease practice must meet applicable requirements for leaving practice, including as set out in the Practice Management Standard of Practice.

12. NOTICE OF REPORTING OBLIGATIONS

It is possible that other CPSM registrants who act as assessors will form the opinion that the candidate is unable to practice medicine safely or that the candidate appears to pose a serious risk of harm to a third party. In such cases, registrants are expected to comply with statutory and CPSM reporting requirements.

13. MPAP NON-PRACTICING STATUS

Per subsection 3.34(2) of the *CPSM General Regulation*, a, "*provisional (MPAP) member may apply for membership in the provisional (non-practising) class if [they are] unable to practise medicine due to a medical condition or while on a statutory or approved leave.*"

A provisional (MPAP) member may move to the non-practicing class as set out in the *CPSM General Regulation* at subsection 3.34(2) due to a medical condition, while on a statutory leave (such as maternity or paternity leave), or an approved leave. The following are approved leaves:

1. a death in the family, or
2. a serious illness or injury of a family member.

Subsection 3.74(1)(c) of the *CPSM General Regulation* provides that, "*If … a provisional (MPAP) member in good standing … ceases to have a practice supervisor, the registrar may change the member's registration to provisional (non-practising) membership for a period of not more than 30 days from the date the member ceases to have a practice supervisor.*" Subsection 3.74(2) of the *CPSM General Regulation* provides that:

> *3.74(2) If the member enters into a subsequent satisfactory arrangement with a practice supervisor before the 30-day period expires, the registrar may change the member's registration to the applicable class listed in subsection (1).*

14. CANCELLATION

Section 3.85 of the *CPSM General Regulation* provides for circumstances where registration in the Provisional (MPAP) Class is cancelled:

> *3.85 The registration of a provisional (MPAP) member is cancelled on the earliest occurrence of the following:*
>
> *(a) the member ceases to be eligible for or registered in the MPAP;*
>
> *(b) the member receives the designation of "unsuccessful in the MPAP".*

Section 7.13 of the *CPSM General Regulation* provides as follows:

> *7.13(1) A participant whose registration is cancelled under section 3.85 may apply for registration only as a regulated associate member in one of the following classes:*
>
> *(a) educational (medical student);*
>
> *(b) educational (physician assistant);*
>
> *(c) educational (resident);*
>
> *(d) clinical assistant (full).*
>
> *7.13(2) To avoid doubt, a participant whose registration is cancelled under section 3.85 is not permitted to apply for any class of regulated or regulated associate membership other than the ones listed in clauses (1)(a) to (d).*

15. IMPACT OF APPEAL PROCEEDINGS AT THE MANITOBA FACULTY

The Manitoba Faculty may afford an appeal process to those participating in MPAP in the event that they are dismissed or deemed "*unsuccessful*". The registration of such individuals with CPSM would usually be cancelled when they cease to be eligible for or registered in MPAP. However, when a registrant appeals a dismissal or finding that they were "*unsuccessful*", they will be considered to be on an "*approved leave*" for the purposes of subsection 3.34(2) of the *CPSM General Regulation* while appeal proceedings are ongoing and may therefore apply for conversion from the Provisional (MPAP) Class to the Provisional (Non-Practicing) Class during appeal proceedings.

PRACTICE DIRECTION

Professional Practice and Inactivity

DRAFT

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 registrants with respect to the subject matter relevant to the practice of medicine. Practice Directions provide more detailed information than contained in *The Regulated Health Professions Act*, Regulations, Bylaws, and Standards of Practice issued by CPSM. All registrants must comply with Practice Directions, per s. 86 of *The Regulated Health Professions Act*.

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

PREAMBLE

This Practice Direction sets out requirements for registrants regarding the need to recognize the limits of their skills and knowledge, and steps that need to be taken when expanding their professional practice to enter areas of inactivity (e.g., new areas of practice). It also includes special requirements for family physicians to include obstetrics or anaesthesia in their professional practice.

CONTENTS

1. APPLICATION OF THIS PRACTICE DIRECTION

1.1. This Practice Direction applies to all regulated registrants (i.e., full, and provisionally registered physicians) and all regulated associate registrants who are registered as a resident or assessment candidate. The professional practice of Clinical and Physician Assistants is determined by their approved Practice Descriptions (see Part 8 of the *CPSM General Regulation*), which are not the subject of this Practice Direction.

2. DEFINITIONS

2.1. For the purposes of this Practice Direction:

'Area of inactivity' means an area of practice in which a registrant has not practiced within three (3) or more years. This includes an area in which the registrant has never practiced.

'Professional practice' has the same meaning as is set out at subsection 1.2(1) of the *CPSM General Regulation*:

> '*professional practice' means, for the purpose of the CPSM General Regulation, a member's specific area of practice in a field of practice within the scope of the practice of medicine."*[1]

The term **'active scope of practice'** as used in this Practice Direction is interchangeable with the term **'professional practice'**. A registrant's active scope of practice (or professional practice) includes their:

- **'practiced scope'**, which means the usual activities that constitute a registrant's core professional practice, and
- **'available scope'**, which means activities that the registrant can safely and competently perform, such as diagnosis and treatment of rarely encountered conditions, and therefore forms part of the registrant's active scope of practice.

3. REGISTRANT'S PROFESSIONAL PRACTICE

Active scope of practice

3.1. A registrant's active scope of practice (or professional practice) is determined by several factors including formal education, training, and certification(s), participation

[1] Section 3 of the *Practice of Medicine Regulation* further defines the "*scope of practice of medicine*" for the purposes of the RHPA.

in continuing professional development, and the registrant's clinical experience. Relevant factors to consider regarding clinical experience include:

- the patient population and demographics,
- reserved acts and procedures performed,
- differential diagnoses or complications addressed in practice,
- treatments and management provided, including prescribing, and
- the practice environment, including practice context (e.g., institutional, or non-institutional, and available supports and resources).[2]

3.2. Information about a registrant's professional practice is obtained by CPSM at the time of initial registration.[3] Applicants for registration are required, as applicable depending on the class applied for, to establish that they have engaged in the professional practice that they intend to practice in Manitoba within the approved period, which is three (3) years (i.e., the recency of practice requirement). In the case of an applicant who has just completed qualifying post-graduate medical education, the recency requirement is satisfied.

3.2.1. Applicants for registration that do not meet the recency of practice requirement may be eligible for registration as an assessment candidate.[4]

3.3. Regulated registrants (i.e., full, and provisional registrants) initially entering the independent practice of medicine do so based on their registrable qualifications and credentials, which comprehend their medical education, training, and clinical experience. They are limited in scope by their learned competencies and the certificate of practice issued by CPSM, which lists their field of practice and may also list exclusions, inclusions, or other terms and conditions.

<u>Field of practice</u>

3.4. Pursuant to the *CPSM General Regulation*, Manitoba has a defined licencing system for medical practitioners. Accordingly, the professional practice of registrants is limited to the field of practice identified in their certificate of practice subject to any denoted inclusions, exclusions, or other terms and conditions.

3.4.1. The interpretation or understanding of what the named field of practice comprises, including the reserved acts that fall within that field of practice (see section 4 of the RHPA), is a matter of professional convention. CPSM

[2] Subsection 9.6(1)(i) of the *CPSM General Regulation* provides that a registrant's public profile information must include "*in the case of a regulated member, [their] current field or fields of practice and, if the registrar considers it necessary or advisable, the member's current professional practice*".

[3] Subsection 3.2(1) of the *CPSM General Regulation* at point 11 requires that applicants for membership provide, "*A satisfactory description of the applicant's most recent professional practice and proposed professional practice*."

[4] See the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class'.

will generally follow descriptions of fields of practice established by the CFPC and the RCPSC. The registrant's specific post-graduate medical education will also be a relevant factor (i.e., residency, fellowship, and professional credentials).

3.4.2. There is no bright-line test to delineate fields of practice, and specific medical procedures or reserved acts are not always compartmentalized to just one field (e.g., family practice, or specialty field of practice). In this regard, registrants' specific education, training, experience, and professional judgment respecting observance of their limitations is important in resolving grey areas.

3.4.3. Listing the field of practice on a registrant's Public Profile (see Part 9 of the *CPSM General Regulation*) and any inclusions, and exclusions, or other terms and conditions, is integral to CPSM's public protection mandate in that it ensures the public has access to a specific registrant's educational background and authorized professional practice.

3.5. Areas of special interest may also be listed on the Public Profile. Section 6.7. of the *CPSM General Regulation* provides for the use of the phrase "*special interest in*" or "*practice restricted to*":

> *6.7(1) A regulated member who is not registered on the specialist register is permitted to use the phrase "special interest in" or "practice restricted to", or both, when referring to the member's professional practice if*
>
> *(a) the member's field of practice is not one that is listed in clause 2.10(2)(b) as a specialty field of practice; or*
>
> *(b) the member's field of practice is listed in clause 2.10(2)(b) as a specialty field but the member's registration does not indicate that he or she is qualified to practise as a specialist in that specialty field.*
>
> *The phrase must appear immediately before the member's field of practice.*
>
> *6.7(2) As an aid to the reader, the following are examples of such phrases:*
>
> *(a) a member with a special interest in sports medicine;*
>
> *(b) a family practitioner with a special interest in psychiatry;*
>
> *(c) a member with a special interest in and practice restricted to oncology.*

<u>Name under which registrants may engage in practice</u>

3.6. No registrant or medical corporation may practice medicine under any name other than the name that is registered with CPSM, unless the Registrar has approved, in

writing, the name under which the registrant or medical corporation intends to practice medicine. A registrant or medical corporation desiring to practice under the name of a clinic, facility or business name that is not registered with CPSM, must send a written request to the Registrar to approve the name the registrant or medical corporation wishes to practice under. The name under which a registrant or medical corporation practices medicine must be published on their Physician Profile.

4. PRACTICE MUST BE SAFE AND COMPETENT

4.1. As a general and overarching requirement, registrants must be safe and competent to practice in a particular area of practice before they may do so. Section 1.3. of the *CPSM General Regulation* provides:

> *1.3 For the purpose of [the CPSM General Regulation], a member is considered to be competent to engage in [their] professional practice if the member has the requisite knowledge, skill and judgment to perform all aspects of that practice.*

4.2. Registrants are expected to recognize the limits of their skills and knowledge and not practice beyond those limits. The Code of Ethics provides:

> *A humble physician acknowledges and is cautious not to overstep the limits of their knowledge and skills or the limits of medicine, seeks advice and support from colleagues in challenging circumstances, and recognizes the patient's knowledge of their own circumstances.*

4.3. The RHPA and *Practice of Medicine Regulation* set out requirements related to the performance of reserved acts:[5]

4.3.1. Subsection 6(1) of the *Practice of Medicine Regulation* states that, "*In the course of engaging in the practice of medicine, a member is authorized — subject to the regulations made by the council and any conditions on [their] certificate of registration or certificate of practice — to perform the reserved acts referred to in section 4 of [the RHPA]*."

4.3.2. Subsection 6(2) states that "*Despite subsection (1), a member may only perform a reserved act that he or she is competent to perform and that is safe and appropriate to the clinical circumstance*".

4.4. Registrants are expected to remain current in their professional practice. The Code of Ethics provides that registrants are expected to:

- *Develop and advance your professional knowledge, skills, and competencies through lifelong learning.*

[5] See sections 4 and 5 of the RHPA.

- *Foster curiosity and exploration to further your personal and professional development and insight; be open to new knowledge, technologies, ways of practising, and learning from others.*

4.5. All registrants of CPSM are required to meet the continuing competency requirements set out at Part 10 of the *CPSM General Regulation* and CPSM's Continuing Professional Development Practice Direction.

5. EVOLUTION OF PROFESSIONAL PRACTICE VERSUS ENTERING AN AREA OF INACTIVITY

5.1. A registrant's professional practice can change over time, with some aspects being lost to inactivity or gained through appropriate training, education, and experience.

5.2. For the purposes of the *CPSM General Regulation* and this Practice Direction, a registrant or applicant for registration who has not practiced within an area or areas of practice within three (3) years, which is the considered "*the approved time period*" for the purposes of subsections 3.8(c), 3.44(1)(ii), and 3.44(2)(ii) of the *CPSM General Regulation*, is deemed to be inactive in the respective area or areas (i.e., the area is outside their active scope of practice).

5.2.1. For greater clarity, a registrant or applicant who has not practiced medicine at all for a continuous period of three (3) or more years is considered inactive in all areas of the scope of practice of medicine for the purposes of the *CPSM General Regulation*.

5.3. Registrants are not permitted to practice in a new area (i.e., an area of practice where they are inactive) unless and until they have been approved to do so in accordance with sections 3.44 to 3.47 of the *CPSM General Regulation* (i.e., the assessment provisions).[6]

5.3.1. As an exception, this assessment requirement does not apply to registrants entering professional practice in a position focused on clinical teaching, research, or administrative work.

5.3.2. For the purposes of the *CPSM General Regulation* and this Practice Direction, CPSM does not consider adding non-surgical cosmetic/aesthetic procedures to a member's professional practice as entering a new area of practice. However, this must be done in accordance with CPSM's Standard of Practice for Office Based Procedures.[7]

5.4. Relevant considerations in determining whether a registrant is entering an area of inactivity (i.e., significantly changing their professional practice to include one or more new areas of practice), as opposed to an evolution of an ongoing professional

[6] See the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class'.
[7] See Standard of Practice for Office Based Procedures.

practice that does not require assessment (e.g., adopting a new treatment modality), include the following:

5.4.1. whether the subject matter falls within an area of practice that was covered by past formal education, training, or certification,

5.4.2. whether the subject matter has been a focus of continuing professional development,

5.4.3. whether the registrant has the knowledge, skill, and judgment to perform all aspects of the area of practice,

5.4.4. any significant change in patient population or demographics,

5.4.5. whether the subject matter involves the performance of reserved acts not previously included in the member's area of practice,

5.4.6. whether the subject matter involves differential diagnoses or complications not previously included in the registrant's area of practice,

5.4.7. whether the subject matter involves treatments or management not previously included in the registrant's area of practice, and

5.4.8. any significant changes to the practice environment, including practice context (e.g., institutional, or non-institutional, available supports and resources, etc.).

5.5. Inactivity may result from a general absence from all clinical activity or specific absence from one or more areas (i.e., the registrant or applicant has excluded one or more areas of clinical practice either through restriction of their practice or by virtue of their practice in a specific practice setting). Examples of inactivity include registrants or applicants for registration who have not practiced in relation to one or more of the following areas in the previous three-year period:

- chronic pain management,
- addictions medicine,
- endoscopy,
- public health,
- rural or urban emergency medicine,
- skin disorders,
- sleep medicine, and
- surgical cosmetic/aesthetic medicine.

This is not an exhaustive list.

5.6. Registrants are expected in all circumstances to use good clinical judgment in considering whether they are significantly changing their professional practice to include one or more areas of inactivity.

5.6.1. Registrants who are uncertain should contact the Registrar of CPSM for information.

5.7. Registrants or applicants who wish to practice in an area or areas of inactivity are required to comply with Part 6 of this Practice Direction.

6. ENTERING OR RE-ENTERING AN AREA OF INACTIVITY

Practicing registrants changing professional practice to enter an area of inactivity:

6.1. Regulated registrants registered in the Full (Practising) Class, Provisional (Specialty Practice-Limited) Class, or the Provisional (Family Practice-Limited) Class who intend to change their professional practice to include one or more new areas of practice in which they have not practiced within the previous three (3) years (i.e., areas of inactivity) must:

6.1.1. report their intention to CPSM in accordance with the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class',

6.1.2. apply in the approved form to be assessed in accordance with subsection 3.44(1) of the *CPSM General Regulation*, and

6.1.3. refrain from entering the area of inactivity until they are approved to do so by the Registrar.

New applicants and non-practicing registrants re-entering practice:

6.2. Applicants who are:

6.2.1. registrants in a non-practising class and are inactive, or

6.2.2. applicants for registration with CPSM who are not registered in any class and who meet the requirements for the Full (Practising) Class, Provisional (Academic — S. 181 Faculty) Class, Provisional (Specialty Practice-Limited) Class, or Provisional (Family Practice-Limited) Class but for recency of practice requirement (i.e., have not practiced in three (3) years)

must apply to be assessed in accordance with subsection 3.44(2) of the *CPSM General Regulation* before they may be approved to re-enter the practice of medicine. The 'Council Policy - Assessment Candidate (Re-entry to Practice) Class' sets out applicable policies and procedures.

New applicants with recent practice experience entering an area of inactivity:

6.3. CPSM requires that new applicants for membership provide details about their most recent professional practice and their intended professional practice in Manitoba. Applicants are required to advise whether their intended practice includes areas of inactivity. Applicants who meet the requirements for full or provisional registration who wish to enter an area of inactivity will be registered in the usual way but must apply in the approved form to be assessed in accordance with subsection 3.44(1) of the *CPSM General Regulation*, and refrain from entering the area of inactivity until they are approved to do so by the Registrar. The 'Council Policy - Assessment Candidate (Re-entry to Practice) Class' sets out applicable policies and procedures.

Required assessment respecting section 3.44 of the *CPSM General Regulation*:

6.4. The degree of assessment indicated and extent of any additional education and training that may be required before approval is granted to enter an area or areas of inactivity will depend on the nature of the re-entry or change in professional practice. The individualized process for determining these components in respect to assessment candidates will be determined by the Registrar under section 3.44 of the *CPSM General Regulation*, this Practice Direction, and the 'Council Policy - Assessment Candidate (Re-entry to Practice) Class', which sets out applicable policies and procedures. The process will usually include:

6.4.1. a needs assessment,
6.4.2. any necessary training and education,
6.4.3. review of appropriate terms and conditions, and
6.4.4. a final assessment where appropriate.

7. FAMILY PRACTICE INCLUDING OBSTETRICS OR ANAESTHESIA

Family practice with anaesthesia

7.1. Pursuant to subsections 2.5(1)(c) and 2.10(2) of the *CPSM General Regulation*, registrants who practice family medicine will have one of the following indicated in the registry: family practice with anaesthesia, or family medicine without anaesthesia. The Registrar may only grant registration and a certificate of practice to family practice physicians with anaesthesia included if the physician has satisfactorily completed twelve months formal training in anaesthesia in an approved teaching centre.

7.1.1. Family practice physicians holding registration and a certificate of practice expressly including anaesthesia as of the implementation of this Practice Direction may continue to hold that registration and a certificate of practice even though they may not meet the foregoing requirement.

7.1.2. The Registrar must impose the following conditions on the registration and certificate of practice of family practice physicians including anaesthesia in their practice:

1. Except in emergencies, limit anaesthesia to patients in physical status I, II and III according to the American Society of Anaesthesiologists Protocol:
   i. ASA I - A normal healthy patient.
   ii. ASA II - A patient with mild systemic disease.
   iii. ASA III - A patient with severe systemic disease that limits activity but is not incapacitating.
   iv. ASA IV - A patient with an incapacitating systemic disease that is a constant threat to life.

v. ASA V - A moribund patient not expected to survive 24 hours with or without operation.

2. Anaesthesia for intrathoracic or neurosurgical procedures must not be undertaken.

Family practice including obstetrics

7.2. Physicians registered to practice in the field of family medicine must not practice obstetrics unless the following conditions are met:

7.2.1. The family practice physician must have completed acceptable post-graduate clinical training in obstetrics and practiced obstetrics within the past three (3) years.

1. Family practice physicians who do not meet the foregoing requirement and wish to provide obstetrical care must do so in accordance with the Council Policy - Assessment Candidate (Re-entry to Practice) Class. This must include completing acceptable post-graduate clinical training in obstetrics, if not already completed.

7.2.2. Family practice physicians who are registered with entitlement to practice obstetrics, but who have not performed any deliveries for more than three (3) years may provide prenatal care to patients but may not do deliveries.

7.3. Family practice physicians who have not completed acceptable postgraduate clinical training in obstetrics and who are not registered with entitlement to practise obstetrics must refer a patient to an appropriately qualified physician:

7.3.1. Before fourteen (14) weeks of pregnancy, or

7.3.2. if the diagnosis is established after fourteen (14) weeks, as soon as possible after diagnosis.

COUNCIL POLICY - DRAFT

Assessment Candidate (Re-entry to Practice) Class

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

PREAMBLE

This Policy applies to registrants who wish to change their professional practice by entering an area of inactivity (e.g., a new area of practice), and to registrants or applicants for registration who are entirely inactive and wish to re-enter practice.

Assessment candidates may be registered in the Assessment Candidate (Re-entry to Practice) Class to meet re-entry to practice requirements, or, if appropriate, they may continue to hold their existing registration while undertaking training in the new area, provided they continue to meet all other requirements.

Registration in the Assessment Candidate (Re-entry to Practice) Class is only available to those who meet all criteria for registration except the recency of practice requirement in one of the following classes: Full (Practicing), Provisional (Academic – s. 181 Faculty), Provisional (Specialty Practice - Limited), and Provisional (Family Practice - Limited).

CONTENTS

1. INACTIVITY

1.1. As stated in the Practice Direction – Professional Practice and Inactivity, the "*approved time period*" for the purposes of subsections 3.8(c), 3.16(1)(d), 3.19(1)(d), 3.44(1)(b), and 3.44(2) of the *CPSM General Regulation* is three (3) years immediately prior to the date of application. An 'inactive physician' means a physician who has not engaged in the field or fields of practice in which they intend to practice for a period of three (3) or more years. A physician is deemed to be inactive in an area of practice if they have not actively practiced in the area for a period of three (3) or more years. This includes an area in which the registrant has never practiced.[1]

2. PRACTICING REGISTRANTS WHO WISH TO ENTER AN AREA OF INACTIVITY

2.1. For practicing registrants of CPSM who wish to enter an area of inactivity, the degree of assessment indicated and extent of any additional education and training required before approval is granted by the Registrar to enter the area of inactivity will depend on the nature of the change in professional practice. These components will be considered by the Registrar under the framework for assessment candidates that is established at Part 3 of the *CPSM General Regulation,* the Professional Practice and Inactivity Practice Direction, and this Policy.

2.2. Registration requirements for the Assessment (Re-entry to Practice) Class relating to registrants registered in the Full (Practising) Class, Provisional (Specialty Practice-Limited) Class, or Provisional (Family Practice-Limited) Class who intend to change their professional practice to include one or more areas of inactivity (a.k.a., new areas) are found at subsection 3.44(1) of the *CPSM General Regulation*, which provides as follows:

> *3.44(1) The registrar may register an applicant in the assessment candidate (re-entry to practise) class if the applicant*
>
> *(a) is registered in the full (practising), provisional (specialty practice-limited) or provisional (family practice-limited) class;*
>
> *(b) indicates that he or she intends to change his or her professional practice to include one or more new areas of practice and he or she has not practised within those areas within the approved time period while registered in the full (practising), provisional (specialty practice-limited) or provisional (family practice-limited) class; and*
>
> *(c) submits to the registrar a written description of*
>
> *(i) the applicant's most recent professional practice and the area or areas to which the applicant intends to change his or her professional practice, and*

[1] See paragraph 2.1 of the Practice Direction – Professional Practice and Inactivity.

(ii) a re-entry plan that meets the approved requirements.

3. APPLICANTS AND REGISTRANTS WHO ARE INACTIVE

3.1. Consideration as to whether an assessment candidate who is an inactive registrant (i.e., non-practicing) or an inactive applicant for registration is safe and competent to re-enter practice after a period of inactivity will be considered under the framework for assessment candidates established at Part 3 of the *CPSM General Regulation,* the Professional Practice and Inactivity Practice Direction, and this Policy. Subsection 3.44(2) of the *CPSM General Regulation* provides as follows:

3.44(2) The registrar may register an applicant in the assessment candidate (re-entry to practise) class if the applicant meets each of the following requirements:

(a) the applicant must establish that

(i) he or she was registered in the non-practising membership class immediately before applying for registration in this class, or

(ii) he or she was not registered in any membership class;

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

(i) the requirements for full (practising) membership other than the minimum practice requirement under clause 3.8(c),

(ii) the requirements for provisional (academic — s. 181 faculty) membership,

(iii) the requirements for provisional (specialty practice-limited) membership other than the minimum practice requirement under clause 3.16(1)(d),

(iv) the requirements for provisional (family practice-limited) membership other than the minimum practice requirement under clause 3.19(1)(d);

(c) the applicant must submit to the registrar a written description of

(i) the applicant's most recent professional practice and the area or areas to which the applicant intends to change his or her professional practice, and

(ii) a re-entry plan that meets the approved requirements.

4. RECENT PROFESSIONAL PRACTICE AND AREA OF INACTIVITY

4.1. For the purposes of both subsections 3.44(1)(c)(i) and 3.44(2)(c)(i) of the *CPSM General Regulation*, a written description in the approved form[2] of the assessment candidate's most recent professional practice and the area or areas to which the candidate intends to change their professional practice must be submitted. This shall include a general description of the following, as applicable:

4.1.1. The candidate's education, training, and certification(s), including any relevant continuing professional development. Attaching a CV is advisable and may be requested in any event.

4.1.2. Details respecting the following relating to current or most recent professional practice:

1. field(s) and area(s) of practice,
2. patient population,
3. reserved acts performed,
4. treatments and management provided, and
5. practice environment.

4.1.3. Details respecting the field(s) and area(s) of practice the candidate intends to enter (i.e., areas of inactivity), including the professional practice components enumerated in subparagraph 3.1.2., above.

5. APPROVED REQUIREMENTS FOR RE-ENTRY PLAN

5.1. To frame this section, the Registrar will apply the following principles in assessing the ability of the assessment candidate to provide safe competent care:

5.1.1. **Status:** As noted above, the candidate must provide the Registrar with a written description of their most recent professional practice and specific practice plans.

5.1.2. **Assessment:** Where appropriate, the candidate must undergo an assessment and, as necessary, relevant education and training before entering an area or areas of inactivity. Assessment is required due to the absence of current practice experience and/or skills and knowledge, even in the absence of evidence of deficiencies in practice.

5.1.3. **Objective:** The overriding objective is to assess whether the candidate has the knowledge, skill, and judgment to perform all aspects of the area of practice in question.

5.2. For the purposes of both subsections 3.44(1)(c)(ii) and 3.44(2)(c)(ii) of the *CPSM General Regulation*, the Registrar must be able to assess, from a registration and qualifications perspective, the ability of the assessment candidate to provide safe and competent care in the area or areas in which they intend to practice, both during and

[2] Forms are available online at: TBD

after assessment. To facilitate assessment, the candidate's re-entry plan must be completed in the required form[3] and include:

5.2.1. A description of any relevant examinations, tests, assessments, training, or education that have been undergone or that the candidate plans to undergo.

5.2.2. Any planned supervision, mentorship, or other supports in respect to the area or areas of inactivity.

5.2.3. The candidate's general plan for ensuring that they have the knowledge, skill, and judgment to perform all aspects of the area or areas of practice in question.

5.2.4. Plans for continuing professional development.

5.3. Upon receipt of the re-entry plan, the Registrar may request further information from the assessment candidate or otherwise respond to concerns about its adequacy. Additionally, the Registrar may require that one or more of the following components be included before the re-entry plan is considered or approved:[4]

5.3.1. That assessment be conducted by a designated Assessor, such as an academic institution (e.g., the University of Manitoba, Rady Faculty of Health Sciences), or an expert consultant.

5.3.2. A period of supervision with a practice supervisor.

5.3.3. A period of mentorship with a practice mentor

5.3.4. Completion of specified examinations, tests, assessments, training, or education that the Registrar considers necessary or advisable, including any recommended by an Assessor, to determine the registrant's competency to engage in the intended area or areas of professional practice.

5.3.5. Any other component the Registrar determines is advisable.

5.4. The need for further education and training must be considered in respect to all re-entry plans. This will be based on two factors:

5.4.1. the candidate's specific practice plans, and

5.4.2. an evaluation of the candidate's current competency, including knowledge and skills.

5.5. To be relevant and appropriate, education and training will need to address any gaps or deficiencies in the candidate's current skills, knowledge, and judgment relevant to the candidate's specific practice plans.

5.6. For assessments conducted in accordance with subsection 3.44(2) of the *CPSM General Regulation*, the subsection 3.44(2)(c)(ii) re-entry plan must include at least one of the following:

5.6.1. An assessment acceptable to the Registrar followed by satisfactory completion of such education and training as is recommended by the Assessor.

[3] Forms are available online at: TBD

[4] An undertaking from the applicant that implements the re-entry plan will usually be required.

5.6.2. The assessment candidate may present to the Registrar a specific education plan and retraining proposal of not less than eight weeks. If the proposal is acceptable to the Registrar, the assessment candidate must satisfactorily complete the retraining as proposed.

5.6.3. The assessment candidate may present to the Registrar a specific mentorship proposal. If the proposal is acceptable to the Registrar, the candidate must satisfactorily complete the mentorship as proposed.

5.7. Assessment candidates may be required to enter an undertaking to CPSM respecting completion of their re-entry plan.

5.8. Subject to obtaining appropriate consents as necessary, the Registrar may consult with an expert consultant or an academic institution in reviewing matters under section 3.44 of the *CPSM General Regulation*.

5.9. Overall, CPSM and the assessment candidate should be sufficiently informed regarding what the assessment will and will not involve and relevant expectations. Assessment may or may not include an orientation period, though this should be noted.

5.10. The primary purpose of this registration class is for assessment, not training experience. It is not a substitute where education and training in the nature of a formal residency program is indicated.

6. NO NEED TO CHANGE MEMBERSHIP CLASS IN CERTAIN CIRCUMSTANCES

6.1. Assessment candidates are not always required to be converted to or registered in the Assessment (Re-entry to Practise) Class. Subsection 3.47(1) of the *CPSM General Regulation* provides as follows:

> *3.47(1) As an exception to section 3.44, a regulated member may apply for a review and assessment without applying to convert his or her registration to the assessment (re-entry to practise) class if he or she*
>
> *(a) intends to change his or her professional practice to include one or more areas of practice in which he or she has not practised within the three years immediately before applying; and*
>
> *(b) is registered in one of the following classes:*
>
> *(i) full (practising),*
>
> *(ii) provisional (academic — s. 181 faculty),*
>
> *(iii) provisional (specialty practice-limited),*
>
> *(iv) provisional (family practice-limited).*

6.2. Where it is determined that there is no need to change membership class for the purposes of assessment under section 3.44, the Registrar may still impose relevant conditions on the member's registration. Subsection 3.47(2) of the *CPSM General Regulation* provides as follows:

> *3.47(2) As an additional condition of registration, the registrar may require any or all of the following:*
>
> *(a) that the member undergo a period of supervision with a practice supervisor;*
>
> *(b) that the member undergo a period of mentorship with a practice mentor;*
>
> *(c) that the member successfully complete the specified examinations, tests, assessments, training or education requirements that the registrar considers necessary or advisable to assess the member's competency to engage in his or her intended area or areas of professional practice.*
>
> *The registrar may also impose any other conditions that the registrar considers necessary or advisable while the member undergoes a review or assessment.*

7. MEMBERSHIP PERIOD, AREA, OR PRACTICE SETTING

7.1. Registration in the assessment (re-entry to practise) class may be limited to a specified period or geographical area or practice setting for assessment purposes. Section 3.45 of the CPSM General Regulation provides as follows:

> *3.45 A person may be registered as an assessment candidate (re-entry to practise) member to practise for a time period or in a geographical area or practice setting for assessment purposes as specified by the registrar.*

8. CONDITION(S) OF REGISTRATION

8.1. The Registrar may impose conditions on the assessment candidate's registration while registered in the assessment (re-entry to practise) class. Section 3.46 of the CPSM General Regulation provides as follows:

> *3.46 As a condition of registration as an assessment (re-entry to practise) member, the registrar may require any or all of the following:*
>
> *(a) that the member undergo a period of supervision with a practice supervisor;*

(b) that the member undergo a period of mentorship with a practice mentor;

(c) that the member successfully complete the specified examinations, tests, assessments, training or education that the registrar considers necessary or advisable to determine the member's competency to engage in his or her intended area or areas of professional practice.

The registrar may also impose any other conditions that the registrar considers necessary or advisable while the member undergoes a review or assessment.

9. COMPLETION OF APPROVED RE-ENTRY PLAN

9.1. When the assessment candidate has satisfactorily completed their re-entry plan, the Registrar will confirm same in writing and issue appropriate certifications in accordance with the *CPSM General Regulation* that are appropriate to the circumstance. Unless subsection 3.47(1) applies, this would include adherence to subsection 3.77(3) of the *CPSM General Regulation*, which provides as follows:

3.77(3) Upon successful completion of the approved re-entry plan, the registration of an assessment candidate (re-entry to practise) may be changed by the registrar, as the case may be, to

(a) full (practising) membership;

(b) provisional (specialty practice-limited); or

(c) provisional (family practice-limited).

10. CANCELLATION

10.1. Section 3.92 of the *CPSM General Regulation* provides:

3.92 The registration of an assessment candidate (re-entry to practise) member is cancelled on the earliest occurrence of the following:

(a) the specified or extended membership period ends;

(b) the member fails to complete the approved re-entry plan;

(c) the member completes the approved re-entry plan and the registrar changes his or her membership class as provided for in subsection 3.77(3).

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 22, 2023
BRIEFING NOTE

TITLE: Standard of Practice Social Media

BACKGROUND

In reviewing the various Standards of Practice as part of the Strategic Organizational Priorities it became apparent that there was no standard on social media use by registrants. It was decided to prepare one, largely utilizing the newly revised Ontario and BC colleges' Standards.

In December 2022 Council reviewed the Draft Standard of Practice for Social Media and approved the draft document to be sent out for consultation with the public, registrants, and stakeholders. The consultation deadline was February 10, 2023. Attached, for your review, are the themes of the feedback received and the feedback itself.

The working group is scheduled to meet on March 9 to review the feedback and make possible changes to the Standard based on the feedback. It is anticipated the revised Standard will be ready for Council to consider final approval at the June meeting.

FOR INFORMATION

This Briefing Note is for information only.

CPSM STANDARD OF PRACTICE
SOCIAL MEDIA
FEEDBACK FROM CONSULTATION THEMES

Consultation Results:

17 Responses in total
13 from Physicians
4 from Organizations

THEMES

1. *Don't Regulate the Personal Space of Registrants*

The Standard can apply to personal use depending upon the connection between the physician's conduct and their professional role. Several have commented that this is overreach into the personal life of a registrant. There is a need to proportionally balance the right to freedom of expression with the regulator's role of protecting the public.

The number of factors to consider the unprofessionalism of the post can include:

- The nature and seriousness of the conduct/communication
- Whether the posting person held themselves out as a medical provider
- The connection between the conduct/communication and the poster's role and the profession.

Comment by CPSM staff: The intent of this was to make the Standard applicable if a registrant was posting information that was antithetical to the character of a physician – such as racist or misogynist posts. It would not apply to an example of a photo of a physician smoking a cigarette in their personal life while also in their professional life counselling patients to quit smoking.

2. *Freedom of Expression*

Good to quote the Charter of Rights and Freedoms regarding freedom of thought, belief, opinion, and expression. The Standard must be flexible enough to allow for the individual expression without offending the Code of Ethics and Professionalism, does not denigrate others, or is otherwise unethical.

3. *Utilize the CPSO Advice Document on Social Media*

CPSO has issued an advice document related to its Standard on Social Media. It expands upon the general principles within the Standard, provides examples, and gives context to the more contentious parts of the Standard. It is recommended that CPSM utilize much of the CPSO document.

Comment by CPSM staff: Much of the information from the CPSO Advice document can be added to a Contextual Information and Resources document that will accompany the CPSM Standard.

4. ***Avoid providing medical advice by social media***
   Very helpful to include this as is in the draft Standard. Keep it in so it is reinforced.

5. ***What is credible evidence and science as the basis for posting medical information?***
   The scientific process involves questioning status quo and status quo changes and this Standard constrains this process that is critical for further developments. Science is always evolving and majority views in medicine are sometimes subsequently proven wrong. We must remain humble and encourage open discussion, that is the path to gaining trust from the public. The importance of open discourse and the role of minority viewpoints are important in shaping the medical community.

6. ***Use of social media to promote solicitation, advertising, and marketing***
   There were various comments about using social media for the purposes of advertising, marketing, business affiliations, conflicts of interest, etc.

   Comment by CPSM Staff: There are separate Standards of Practice on Advertising, Conflict of Interest, and Business Affiliations (Practice Management). Perhaps a reference to these Standards can be made in the Contextual Information and Resources.

7. ***Specifically state the physicians are free to disagree with government, RHA, etc.***
   It is important for registrants to understand the parameters of what the Standard will permit with regard to criticism. This is especially applicable to contentious societal matters such as MAiD and abortion. It is also applicable to health care resources (lack thereof and healthcare transformation initiatives.)

   Comment by CPSM staff: As examples, although a registrant may be able to criticize the government for health care transformation, for lack of funding, for failing to provide programs such as safe injection sites, registrants are not able to post on social media that they disagree with Public Health or Government mandated masks or vaccines. It is important to state that there might be employment or privileging considerations that might place different limits on criticism.

8. ***Institutional Policies and Guidelines***
   It would be helpful to encourage those practising in institutional settings to be familiar with institutional policies and guidelines on the roles of advocacy and other matters on social media.

9. ***Need to clarify use of social media in medical care since it can be expansive.***
   Questions have arisen such as can Facebook messenger be used to contact a patient? Can Facebook be used to inform a community to advise a patient to contact the physician?

10. Standard has vague wording

Some of the requirements mention “reasonable”, “good faith”. These are not defined and what one person might find reasonable might not be reasonable to another.

Comment from CPSM staff: All Standards are written as general principles and include words such as reasonable which means what a group of peers would find reasonable in the circumstances. This takes it from a subjective test to a more objective test.

11. Standard is well written, thoughtful, and will help teach ethics and professionalism.

12. The link to the four regulatory cases is unnecessary.

The cases should be summarized and anonymized to teach registrants about risks and responsibilities but without targeting the individual registrants any further.

13. Online Searching for Patient Information is Problematic

PHIA only permits the collection of personal health information without consent in limited circumstances:

- reasonably be expected to endanger patient’s health or safety or for another person
- it is in the interest of the patient and time or circumstances do not permit collecting it directly form the patient
- the patient is reasonably expected to be providing inaccurate information

Examples of online searching should be able to assist registrants in navigating this tricky area of privacy without the patient’s consent.

14. Enforcement

The first action by CPSM to an improper post usually should be to ask the registrant to remove it. In most instances this will be appropriate, and the matter should end there. However, for some matters such as racism, sexism, inciting violence, revealing personal health info, then further action by CPSM might be required.

Comment
CPSM Registrants
Regarding the Social Media draft proposal—current laws and rules of decency already address almost completely all of the points of actual concern raised. However, trying to further regulate someone's personal life and expression simply because they are a physician, is otherwise completely inappropriate. CPSM has previously demonstrated its inability to realize its own regulatory boundaries, so this is unsurprising; nevertheless, CPSM can still re-evaluate its authoritarianism and follow an ethical compass. (The only point the CPSM should strongly convey to physicians with regards to social media use, is the need to consider the extent of any online medical advice, to avoid offering 'part diagnosis' which may be dangerous; careful to avoid providing what sounds like definitive medical advice without necessarily having all of the required information).
I would recommend adding to the draft that CPSM's approval of social media use by registrants does not advocate that registrants MUST use social media if patients want to do that. For example, some patients may want to communicate by these means but the registrant may not. The draft does not explicitly state that a registrant may choose to not use social media despite patient requests to do so.
The comments below are in response to the draft Standard of Practice Social Media. Regarding statement 4.2.1, I would like to point out that by definition, the scientific process involves continually questioning the status quo and the established way of thinking in order to arrive at a better understanding. Science cannot evolve without free speech and the ability to question. Regarding statement 4.2.3, who decides what is "false, misleading, deceptive or a potential threat to health"? All medical interventions involve weighing risks and potential benefits, therefore all medical treatments can be a potential threat to health. Also, because science is constantly evolving, what is considered true now may not be considered true in the future. The practice of medicine often involves high levels of uncertainty and differing opinions, and it would be good to ackowledge this. In addition, in order to preserve physicians right to free speech, I believe it is important to specify that physicians are free to question government statements and positions publicly. The current wording of the Standard is below: "If discussing general health information on social media for educational or information-sharing purposes registrants must: 4.2.1 ensure the information they present is verifiable by available, credible evidence and science, 4.2.2 acknowledge if they are challenging a widely-accepted position or proposing alternative theories which lack evidence and science, or if their position does not represent the majority of

the medical profession. In these circumstances, the clinical claims and information must not be false, misleading, deceptive, or be a potential threat to health.
4.2.3 be aware of and transparent about the limits of their knowledge, expertise, and scope of practice; and
4.2.4 not misrepresent their qualifications"

My suggested edits for the above paragraph are as follows:
"If discussing general health information on social media for educational or information-sharing purposes registrants must:
4.2.1 ensure the information they present is supported by evidence. Types of evidence can include scientific studies, and personal opinion based on clinical experience. The type of evidence being used to support the statement should be specified.
4.2.2 acknowledge if they are challenging a widely-accepted position or proposing alternative theories ~~which lack evidence and science~~, or if their position does not represent the majority of the medical profession. ~~In these circumstances, the clinical claims and information must not be false, misleading, deceptive, or be a potential threat to health~~. Physicians are free to publicly disagree with the government.
4.2.3 be aware of and transparent about the limits of their knowledge, expertise, and scope of practice; and
4.2.4 not misrepresent their qualifications"

Thank you for the ability to comment on this Standard.

This is a very minor bit of feedback regarding the draft Standard of Practice pertaining to the use of social media.

Please note that 3.2.4 is grammatically incompatible with the points that precede 3.2.4.

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

that is to say, one cannot say "unless document this in the patient record".

I would add that it is inappropriate to use social media for self promotion. A case came to may attention recently where a surgeon was overly critical of another surgeon's expertise stating that his training was inferior to theirs and that patients should beware of the differences in training. This is not only unprofessional, but inaccurate. I wonder who will police these standards?

One aspect of social media that was not discussed in the standards document was solicitation/ adds / marketing. People use social media to make money. They promote links for discounts then get kickbacks, they promote products etc. Physicians on social media are doing this. Is this behaviour ok? It doesn't seem right to me! Here's an example. This doc is from Alberta (@lifeofdrmom)

I am writing to express my concerns about section 4.2.2 of your draft social media policy for physicians. I have a unique perspective on the importance of open discourse and transparency in the medical community.

As a researcher, I have spent the past several years studying mRNA technology and it's applications, including during the early days of the COVID-19 pandemic. During this time, I observed that many widely-accepted views and assumptions about the virus and its transmission were later proven to be inaccurate or incomplete - including but not limited to COVID transmission (fomites vs airborne transmission, that vaccines prevent transmission, and issues regarding myocarditis etc.)

It is for this reason that I believe it is crucial to allow for open discussion and debate among medical professionals, even when opinions may not align with a majority viewpoint. Without this, we risk stifling the advancement of science and the discovery of new truths.

As a physician, I understand the importance of building trust with the public, and transparency is a key component of that. However, I believe it is the role of the college to provide accurate information to the public and not to discourage debate among its members. The college can provide updates on its public website or via public newsletters but it should not discourage any form of debate among its members.

I personally have refrained from discussing certain topics on social media due to concerns about regulatory bodies, but I believe this is detrimental to progress and is not productive. To highlight this, a survey among physicians in New Brunswick (NBMS) showed that a vast minority of physicians felt comfortable knowing about how mRNA vaccines worked - including side effects etc. but a large majority were happy to administer them to patients. I can't imagine that any college is of the position of encouraging physicians to administer therapies which they don't

understand or have limited knowledge of its side effects. Open discussion should be desired, not only for transparency but also to further educate physicians.

Despite having knowledge in this area, I refrained from posting and talking about a nature review article (https://www.nature.com/articles/nrd.2017.243.pdf) which listed the clinical trials for mRNA technologies up until 2018 and discussed the limitations and risks of mRNA technology. Many safety concerns listed in this nature review are true, however, were considered "misinformation" by a majority view at some point during the pandemic. For example, it is true that mRNA therapies were not approved for any indication prior to Covid. It is also true that some clinical trials mentioned in the above review were stopped early due to safety signals from mRNA therapies. It is also true that the shortest vaccine trial prior to covid lasted about 22 months before approval and it was based on already proven technology (shingles vaccine). These true statements would have been fringe during the pandemic - thus, I refrained from any comments solely based on fear from regulatory bodies. I do not think that was productive and it was possibly a missed opportunity to provide insight to potentially the public and some of my physician colleagues.

Inherently, experts and expert panels are composed of a minority of members and the majority of members rely on minority groups to engage in such debate. A minority of members cannot always be correct and thus there should be lots of room for open debate - science is always evolving. We cannot forget that many majority views in medicine are often incorrect (for example the classic example of H. Pylori causing ulcers). We must remain humble and encourage open discussion, that is the path to gaining trust from the public - anything short of this will be divisive.

I urge you to carefully consider the importance of open discourse and the role of minority viewpoints in shaping the medical community.

Thank you for taking the time to consider my thoughts and experiences on this matter.

I think it may be useful to include a provision about anonymous posting, as this is common among younger physicians. I'd suggest that when there is no claim of being a physician or attachment to a practicing physician that CPSM standards to not apply with the same strictness.

In regards to 4.1, I'm unclear if this is about public forum posting only, or to include private direct messaging. Borrowing from some the experiences of my CFS colleagues, I do maintain a "professional" Facebook account that I have used, on rare occasion, to contact individuals through Messenger as they don't have a current phone access but do have that. I have also used Messenger Video to conduct video consults when patients were isolating for COVID and weren't allowed to enter health care facilities. Some research has been done on this, particularly in tele psychiatry, in the USA and found that while these violated HIPPA per se, they did seem as secure and did not seem to violate the spirit of the profession. Maybe clarifying the manner of use of social media and extenuating circumstances would be useful for the Standard?

I have looked at the social media standard of practice.
A concern I have is that I see many colleagues using social medial to advertise "prescription" aesthetic services with incentives and "sales". " Ridiculous giveaways.

Eg social media platform of Form Medical Aesthetics.
I feel this is inappropriate and is coercive to patients in an unethical manner. I am unsure where this is addressed in the standard of practice.
Additionally, how will this standard of practice be tracked? Only by complaint? Will there be a "proactive " approach taken to look at social media of members?
If concerns arise, what happens…. Post removed? Platform removed? Sometimes errors happen due to technological ignorance and sometimes due to stupidity.

Thank you for your email and draft standard of practice on the use of Social Media (SM).

I'm unwilling to accept this document since it contains;
A-Inaccurate bases for developing the document
B-Vague language
C-Subjective interpretation which potentially puts all power in the hands of CPSM staff
D-Overreach

I will give examples for each point;

A-Inaccurate bases for developing the document
"Preamble:
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."
-Section 82(1) A council must, by regulation, establish standards of practice to regulate the quality of practice of its members.
This section of the Regulated Health Professions Act gives the council the power to regulate "quality of practice". However, the document is focused on regulating private lives and activities outside the boundaries of medical practice of its members.

B-Vague language
"Preamble:
Physicians hold a respected place in society. While using social media, professional conduct and communication are important to avoid harm to the public, not adversely impact patient care, preserve the reputation of the profession, and foster a culture of respect."
-Please define harm. Is it physical or emotional or other type?
-Please define reputation of the profession.

"As a guiding principle, registrants are reminded that, irrespective of whether participating in social media is for a personal or professional purpose, prevailing expectations of professional and ethical conduct are the same as when interacting with others in-person. CPSM recognizes that registrants have rights and freedoms under the Charter of Rights and Freedoms, including the freedom of expression, subject to reasonable limits."
-Are you referring to public expectation or government expectations or leadership expectations?
-Please advise where do I find lists of those limits?. Also, please advise who decides them?

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

-Vague language. If, in my personal life, I smoke and in my professional role I treat patients with smoking-related cancer, would this mean I won't be allowed to post personal photos while having a cigarette?

"2.3. Registrants must avoid engaging in conduct on social media that diminishes their professional standing or the reputation of the profession. This requires careful consideration of the potential consequences of their use of social media, both intended and unintended, and how their conduct might reasonably be perceived by others."
-Vague language since how do you define "professional standing" and "reputation of the profession"?
This will put CPSM in direct confrontation with the government that defamed doctors as "wealthy tax cheats"! (https://www.thestar.com/opinion/commentary/2017/09/20/trudeaus-sinister-stand-against-doctors.html?rf)

"Page 2, Footnote
Disruptive behaviour includes inappropriate words, actions, or inactions that interferes with a registrant's ability to collaborate, the delivery of healthcare, or the safety (or perceived safety) of others. Disruptive behaviour may be demonstrated through a single act but is often identified through a pattern of events. Disruptive behaviour may include bullying, attacking, or harassing others and making discriminatory comments. An example of behavior that is not likely to be considered disruptive includes constructive criticism offered in good faith with the intention of improving patient care of the healthcare system."
-How do you judge a person on his "inactions"? Please give examples of disruptive inactions.

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

C-Subjective interpretation which potentially puts all power in the hands of CPSM staff
"2.3. Registrants must avoid engaging in conduct on social media that diminishes their professional standing or the reputation of the profession. This requires careful consideration of the potential consequences of their use of social media, both intended and unintended, and how their conduct might reasonably be perceived by others."
-This is very subjective. Moreover, who decides what is reasonable? Is it the college or the audience or the registrant?

"Page 2, Footnote
Disruptive behaviour includes inappropriate words, actions, or inactions that interferes with a registrant's ability to collaborate, the delivery of healthcare, or the safety (or perceived safety) of others. Disruptive behaviour may be demonstrated through a single act but is often identified through a pattern of events. Disruptive behaviour may include bullying, attacking, or harassing others and making discriminatory comments. An example of behavior that is not likely to be considered disruptive includes constructive criticism offered in good faith with the intention of improving patient care of the healthcare system."
-Perceived by the college or by a SM user?. This is very subjective and who will be the arbitrator?
-Who judges "good faith"? Who judges "good intention"?

D-Overreach
"1.1. This Standard applies to the professional use of social media, but it can also apply to personal use depending upon several factors, for example, the connection between the physician's conduct and their professional role."
-This is a major breach of borders by intervening in personal use of SM. Vague language as "other factors" adds to the fear that CPSM will have a longarm to intervene in personal life. 1.1 should be removed.

"4.3. Advocacy - Many registrants utilize social media as a platform to advocate for system or societal change. While this is an essential role registrants must ensure that any advocacy efforts abide by the above provisions."
-CMPA guidance describes advocacy for "patient's care and improving health system". So why do you exceed the recommendation by including "societal change"?.
-This is an overreach from the CPSM beyond the CMPA view and infringes on member's freedom to express own views on "societal issues". Moreover, this is an invasion of member's privacy by considering issues outside patient's care and health system as domains under the CPSM mandate to regulate.
-4.3 should be removed

In summary; this document needs major revisions because of inaccuracies contained in it, the use of vague language, it is prone to subjective interpretations and above all its overreach over the freedom of expression and private enterprise of registrants.

I would appreciate a detailed reply to the points I mentioned above and for the sake of transparency, which is expected from the CPSM, it will be highly appreciated if the comments received made public. Finally, since this document blurs the lines between professional and public life of registrants, I would ask CPSM to put the final draft for general voting by the registrants so that CPSM is released from any accusations of overreach or work against rights secured by the constitution.
Regards

Observation: I don't have Facebook or the usual social media platforms, so the topic is not personal.

3.2 included in parentheses (or former patient), yet proceeds to list the parameters in which a physician may use social media with regards to a patient, none of which apply to a former patient. Documenting in the chart of a former patient would be covered by PHIA in what manner? Just wondering…

4.2.2 references the opinion of the majority of the medical profession in what appears to be a separate component from the evidence and science. We know from history that the majority of doctors' opinions have not always turned out to be optimal for human health in the long run, as we understand health presently. Physicians in Germany were part of the ethnic cleansing popular opinion, as well as participating, either actively or passively in the elimination of infirm, handicapped and elderly in the 1930's. Our present opinion is that those doctors were not protecting their patients, and were caught up in the popular opinion of the day.

Evidence Based Medicine was a catchword a few years ago, and hardly heard of today. Published reports do not represent EBM unless they pass critical scrutiny of objective reviewers, not connected to the sponsor or authors of the paper. Numerous studies' conclusions have been refuted over time, some after critical review of the paper itself.

I will provide only one example of evidence and opinion discordance. The Manitoba government sponsored a study on sediment in Lake Winnipeg, based on the theory that agricultural fertilizer run-off was contaminating the lake. Sediment from different levels, I believe the deepest was 50 feet (presumably from years ago) was tested and each level had the same amount of phosphates, yet the authors' conclusion, read in the Legislature, was that they remained convinced of the validity of their theory, blaming farmers for the state of Lake Winnipeg. Evidence and opinion, not aligned.

One investigator's evidence is another's source of mockery, a state that physicians should avoid. However, critical appraisal of evidence, whether an n of one, or thousands is necessary to warrant the trust of the public. A scientist on a program about the cosmos said "There is more we don't know than what we do know". I suspect a similar phenomenon in the medical sciences. The majority of people will react similarly in the majority of cases, however, few of us treat the majority when we face a patient, and decide what the optimal treatment and recommendation is for them, on that day. Socrates and Osler agree in the goal of treating the patient with the disease, rather than only treating the disease

The medical value of consuming alcohol has recently undergone a public change. I would guess that the Mormons are neither surprised or amused. Early on in the discussion, a cardiologist remarked that "We WISH that consuming red wine daily was healthy", a comment I have not forgotten.

The story of Vioxx is another example. The science and the media coverage were not aligned. The day after Merck removed Vioxx I spoke to an internist who had now disavowed the entire class of Cox II inhibitors. I asked if they were familiar with the science and politics behind the company's decision, and was told "No". Great drug, misunderstood regarding its antiplatlet properties, which it was assumed to have as part of its class, and did not.

Assuming the majority of physicians are correct in their opinions is a bold position to take, given the history of humans and the history of medicine. Using critically appraised data, and interpreting the data to the degree of confidence the data can provide is usually the approach of guideline committees, and if not, most likely should be the basis for recommendations to the public. The media interpretation is to pass over the bulk of the publication to the bottom line, and summarize it in a manner that is easy to absorb, and that becomes public and most often physician opinion.

To have an intellectual debate over the quality of evidence is challenging, if there was even a medium for that to happen. Letters to the Editor of journals are selected, or rejected, if the question of the author do not aligned with popular opinion, so the opportunity to have a discourse on the merits or pitfalls of a published paper are limited. The first signal of the danger of thalidomide came from an Australian GP, to the mockery of the elite from Boston, nine months before the danger was more universally accepted.

If the College wishes to promote intellectual integrity, scientific validity, and safe practices, a platform to achieve those goals should be in place. In the absence of such a platform, social media becomes a vent for discontent and discouragement. Silencing a minority opinion, or refusing to respond to a legitimate question of science does nothing to elevate the opinion of physicians in the public eye. For the one person who responded to an unorthodox treatment, it is 100% success. The physician who pioneered paediatric chemotherapy for leukaemia was harassed, threatened, fired, and ultimately rewarded with a pioneer in medicine recognition, taking mortality from 100% to 65% and then lower, with refinements in therapy.

If physicians think we know everything there is to know about human health today, then they should advise the cosmologists to pick up the pace.

I agree with the premise that social media is not the ideal platform for intellectual debates, and decorum should always be professional and respectful. Managing social media may be a horse already out of the barn scenario, milk already spilt, the fan already having been struck. Pre-empting the lack of a scientific discussion platform by creating one, within the College, open only to College members, allowing an opportunity to question popular opinion, to challenge author's conclusions, to point out potential conflicts of interest, etc should be a consideration moving forward, a platform that would be within a self-regulating profession, shielded by either anonymity or strict rules of confidentiality to avoid any Individual physician being targeted by government or the public, or the College itself.

Medicine is most often reactive, and rightly so. Is there an opportunity here, in discussing social media behaviour to provide a proactive approach, a platform of constructive discussion, based on the best available evidence, vetted and screened by non-partisan interests?

Thank you for allowing me to provide some feedback and perspective on the recent College of Physicians and Surgeons of Manitoba Draft Standard of Practice for Social Media. I am a physician member of the CPSM and a bioethicist. I often teach and counsel students about the benefits and risks of social media engagement as they become physicians. This well written and thoughtful standard will help me clarify to students what the professional expectations are, and how they need to be mindful of not violating these standards.

Overall I think the Standard is clear and comprehensive. I was pleased to see sections related to seeking out patients personal information from social media (aka patient targeted Googling) and also those related to using social media for advocacy, educational purposes and communicating medical information online. I do think one area that could be added to the standard is a section specifically discussing the responsibilities of those who become social media influencers. Social media influencers are people who have built a reputation for their knowledge and expertise on a specific topic. Some social media influences partner with brands or companies to promote products and services, and benefit monetarily from that partnership. Increasingly, some physicians with social media presence are becoming paid influencers. While the CPSM's Standard of Practice for Advertising and/or the U of M Industry relations policy can theoretically be applied to these influencers, I think the Social Media standard could be strengthened by explicit discussion of expectations for CPSM members who become paid influencers.

Despite my overall support for this Standard, I am very concerned about the contextual factors section of and am hoping that the writing committee will consider amending it in the final version. The section includes links to 4 "case law" examples where social media engagement and how health professionals were sanctioned because of social media activities.

Again, I appreciate the opportunity to comment on this Standard and to advocate for changes to the final version. I hope my suggestions and concerns can help to make the Standard an even better resource and reflection of the CPSMs values as they pertain to social media.

Stakeholders
Hello, thank you for the opportunity to • For transparency, I suggest that the Application statement include what broad factors come into plan when deciding that this standard applies to personal social media use. Also, suggest checking the sentence structure. This Standard applies to the professional use of social media, but it can also apply to personal use depending upon several factors, for example, the connection between the physician's conduct and their professional role. • In the privacy and confidentiality section, suggest referring to the expectation to comply with the law. i.e. MB PHIA legislation 2. Registrants should avoid posting patient information if possible unless for educational purposes. Only post identifiable patient information or patient images to social media if the patient has provided a fully informed consent—even in a closed or private online forum. Once something is posted it is difficult to control further distribution and so consent to post these images should identify this as a risk. Treat photos and videos of a patient made in the context of patient care as part of the patient's medical record. • Item 3.2. Suggest the default is honesty and transparency in how a physician obtained patient information. Suggest rewording this statement to: 3.3.2. Disclose to the patient the source of the information, the clinical rationale, and any other relevant information. Only consider not disclosing if it is not safe or appropriate to do so. College of Registered Nurses of Manitoba
See attached letter from CMPA
See attached letter from College of Pharmacists of Manitoba
See attached letter from Doctors Manitoba
See attached letter – Manitoba Health – Assistant Deputy Minister

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

January 30, 2023

Via email: CPSMconsultation@cpsm.mb.ca

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

Dear Anna,

Re: Consultation on the Draft Social Media Standard of Practice

The Canadian Medical Protective Association ("CMPA") appreciates the opportunity to participate in the consultations on the draft Social Media Standard of Practice.

The CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medico-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 108,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medico-legal issues.

With the increased use of social media in recent years, the CMPA welcomes the College's initiative to develop a Social Media Standard. Given the Saskatchewan Court of Appeal decision in *Strom v Saskatchewan Registered Nurses Association*,[1] it is also appropriate that the Standard recognizes a medical professional's freedom of expression when seeking to set out expectations that may impact their Charter rights. The CMPA's comments focus on providing additional guidance to supplement the draft Standard, and more specifically, on the following elements:

- Personal use of social media;
- False, misleading and deceptive information;
- Indirect collection of patient information through social media;
- Institutional policies related to advocacy on social media; and
- Professionalism and reputation of the profession.

[1] 2020 SKCA 112 (CanLII)

Personal use of social media

We recommend the College elaborate on factors that should be considered with respect to physicians' personal use of social media. Currently, the draft Standard indicates that it can apply to personal use depending upon "several factors", but mentions only one such factor, namely the connection between the physician's conduct and their professional role.

The College may be interested to know that the College of Physicians and Surgeons of Ontario's ("CPSO") Advice document on Social Media proposes a number of factors to consider when determining whether personal use of social media may be found to be unprofessional.[2] These include, but are not limited to, the nature and seriousness of the conduct and/or communication, whether or not the physician was known to be, could reasonably be known to be, or represented themselves as a member of the profession, and the connection between the conduct and/or communication and the physician's role and/or the profession. These contextual factors align with those considered in the *Strom* decision to proportionately balance the right to freedom of expression with the professional order's role of protecting the public.

False, misleading and deceptive information

The CMPA recommends further clarifying the expectations regarding false, misleading or deceptive information in the draft Standard.

Paragraph 4.2.2 of the draft Standard currently provides that when posting content challenging a widely-accepted position or proposing alternative theories, physicians must ensure clinical claims and information is not false, misleading, deceptive, or a potential threat to health.

In the CMPA's view, physicians would benefit from more detailed discussion of the College's expectations in this regard. In addition to providing examples of what could be considered false, misleading or deceptive information, it would be helpful to clarify reasonable exceptions. For example, the CPSO's Advice Document states that information that evolves rapidly and may no longer be accurate shortly after it is posted would not constitute misleading or deceptive information if it reflects the best available information at the time it was posted.

Online search for patient information

We recommend that the draft Standard better align with the *Personal Health Information Act* ("*PHIA"*) in relation to the indirect collection of personal health information. It would also be helpful if the Standard provided additional examples of situations that may justify a physician conducting an online search for patient information in the absence of consent.

In particular, the draft Standard should alert physicians that the *PHIA* only permits indirect collection of personal health information without consent in the circumstances set out in section 14(2) of *PHIA*, including where:

- collecting information directly from the individual could reasonably be expected to endanger the individual's health or safety or that of another person;

[2] College of Physicians and Surgeons of Ontario, Advice to the Profession, Social Media (June 2022), online: https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Social-Media

- collecting information is in the interest of the individual and time or circumstances do not permit collecting directly from the individual;
- collecting the information directly from the individual could reasonably be expected to result in inaccurate information.

It would be helpful if the Standard offered examples of situations where it would be reasonable for the physician to seek out patient information online without patient consent. For example, it may be reasonable in appropriate cases to search for information about a patient online where there is a risk of serious bodily harm to that patient or to others and danger is imminent, or in order to deliver appropriate care to a patient who presents to the emergency room unresponsive or otherwise unable to provide critical information.

Institutional policies and guidelines

It would be helpful if paragraph 4.3 of the draft Standard encouraged physicians practising in institutional settings to be familiar with any institutional policies or guidelines on the role of physicians in advocacy activities in the context of social media.

Some institutions may require that express permission be obtained before a physician embarks on advocacy activities on social media that could be interpreted as directly involving the institution. It may also be helpful to encourage physicians, before they engage in advocacy activities on social media, to consider whether it may be necessary or appropriate to notify the institution's administration and/or other members of the care team, even if no policies or guidelines require it.

Professionalism and reputation of the profession

We recommend that the College provide examples of conduct that diminishes the reputation of the profession or fails to uphold professionalism.

Paragraph 2.3 of the draft Standard requires that physicians avoid conduct that diminishes physicians' professional standing and the reputation of the profession. Paragraph 2.4.3 mentions upholding the standards of medical professionalism.

For example, the College of Physicians and Surgeons of Alberta recommends only posting content physicians would be comfortable having quoted on the front page of the paper.[3] The CPSO's Advice document on Social Media specifies that professionalism requires balancing duties towards individual patients, the public, the healthcare system, colleagues and themselves, and should integrate considerations of equity, diversity, and inclusion. It indicates that upholding the reputation of the profession includes acting in accordance with the law, participating in professional regulation, adhering to clinical standards, demonstrating professional competence, and maintaining the same standard of professional conduct in an online environment as expected elsewhere.

While the section "Recent Case Law on Social Media" provides helpful illustrations of conduct found to be unprofessional, we are concerned the short summaries of legal cases may lack detail and could be misinterpreted. It would be preferable if the College offered its own examples, informed by case law, regarding conduct the College considers unprofessional in this context.

[3] College of Physicians and Surgeons of Alberta, Advice to the Profession, Social Media (August 2022), online: https://cpsa.ca/wp-content/uploads/2020/06/AP_Social-Media.docx.pdf

CMPA Publications

The CMPA is pleased to see that the draft Standard refers to various CMPA articles. It would be beneficial if it also referenced the following CMPA publications:

Social media: The opportunities, the realities
Participating in health advocacy

We trust these comments will be of assistance to the College in finalizing its draft Standard of Practice.

Yours sincerely,

Lisa Calder, MD, MSc, FRCPC
Chief Executive Officer

LAC/ml

cc. Dr. J.H. Brossard

Standard of Practice Social Media Consultation

The College of Pharmacists of Manitoba (CPhM) recognizes the benefits and potential risks of using social media. CPhM was involved in collaborating with other provincial health regulatory colleges through the Manitoba Alliance of Health Regulatory Colleges to develop a social media and professionalism module, Pause Before You Post: Social Media Awareness, and appreciates the opportunity to provide feedback on this Standard of Practice.

1. General Comment

”Physician”, “registrant”, and “member” are used interchangeably throughout the Standard. Does the Standard apply to associate members such as Physician Assistants or Clinical Assistants? If so, suggest using alternate wording for “physician” (e.g., medical practitioner).

2. Definition

The clarification on the exclusion of Cortext is helpful here.

3. Professionalism, Relationships and Boundaries

This section is a good reminder that whether in front of the patient or online, the same rules of communication and professional expectations are the same. Highlighting the importance of setting boundaries and maintaining the image of a trusted healthcare professional is crucial in the use of social media.

4. Privacy and Confidentiality

This section may benefit from incorporating information about how PHIA still applies to social media and the importance of maintaining those principles when engaging in social media and the obligation of a medical professional to take reasonable steps to ensure that personal information is protected. Also, to remind registrants that patients have a right to access their records no matter the format in which they are created or kept and the need to document the content shared or communications.

5. Communicating Medical Information

If a registrant creates a professional social media account (e.g., Facebook page for themselves/practice) would it be the expectation that they monitor posted messages, either for response or for removal of inappropriate messages? If so, this section may benefit from having a comment on the responsibility of the registrant to monitor their account or deactivate accounts that they are no longer active on. A reference to social media not being a secure or private form of communication may be helpful.

6. Contextual Information and Resources

The links in this section do not work. The cases provided give a good reminder of the importance of following the Standard of Practice and how important is it to be cognizant of what is being posted on social media.

Kind regards on behalf of the College of Pharmacists of Manitoba,
Emily Kaminsky, Practice Consultant

Doctors Manitoba
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R3X 0E8 Canada

T: 204 985-5888
T: 1 888 322-4242 (toll free)
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Via Email

February 10, 2023

Dr. Anna Ziomek, Registrar
The College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg, MB R3J 3T7
CPSMconsultation@cpsm.mb.ca

Dear Dr. Ziomek,

Thank you for the opportunity to provide a submission on the draft CPSM Standard of Practice for Social Media (the "Standard").

We appreciate the opportunity to make a submission on behalf of our mutual members. We can also comment on our experience trying to prevent our mutual members from encountering difficulties through their social media activity.

The nature of the problem

It is undisputed that physicians bear a high responsibility for their actions and words.

The advent of social media has not changed this responsibility. There is no fundamental difference between statements made on social media, and those made in the physician's lounge, coffee shop, hockey rink, a restaurant, or in traditional media. The greater scrutiny flows from social media allowing for someone's words (or explicit or tacit support for an idea or position) to be broadcast, widely disseminated, and leave an electronic trail.

We concur with the CPSM that physicians' social media posts can impact not only an individual patient, but the reputation of the medical profession. Accordingly, we do engage with physicians in real time if we become aware of social media activity which we believe could be damaging to the profession or be seen as a breach of physicians' obligations under the Code of Ethics or Standards of Practice of the CPSM. Of course, we can only provide guidance to physicians as we are not the regulator (as some physicians are quick to remind us).

It is no surprise that physicians' statements haves been under even greater scrutiny since the beginning of the COVID-19 pandemic. The pandemic has highlighted the challenges for physicians, particularly but not only through statements on social media. Some members of the public who deny the gravity of the pandemic, or oppose the efficacy of masks, vaccines, and other measures, were and are quick to share any pronouncement by a "Dr." supporting their position (which sometimes, but not always, turns out to be a doctor of chiropractic, natural medicine, or even a veterinarian). Statements taken out of context, or the sharing of dubious articles, only add to the challenge. At the same time, physicians who choose to promote best practices – whether through traditional media, on social media, or otherwise - were and are frequently challenged or attacked on social media.

The increasing alignment of political ideology with certain medical issues has complicated matters. Reproductive choice, medical assistance in death, the decriminalization of drugs, and even vaccinations have become issues of intense debate. With the exception of vaccinations, each of these issues should allow for a range of opinions among our physicians (as long as these opinions aren't expressed in a way which violates the Code of Ethics or other areas of the Standards of Practice).

We believe that every physician has the right to express their own beliefs, even if they may differ from their colleagues (and are duly acknowledged as such) or are outside of the political mainstream. It is only where – in the absence of other aggravating factors - those beliefs touch upon medical areas that there should be a disciplinary role for the CPSM.

Accordingly, the Standard should not vary greatly from the existing rules in the Code of Ethics and the Standards of Practice respecting any other oral or written statements made by physicians.

We now turn to the wording of the Standard, and the Contextual Information and Resources.

Preamble

The Preamble in the proposed Standard appropriately notes the right of physicians to freedom of expression under the Charter of Rights and Freedoms, subject to reasonable limits. In our view, this should not be the second part of the last paragraph of the Preamble but should, as in the CPSO's Policy on Social Media, be contained in its own paragraph near the top of the Preamble.

A revised first paragraph of the Preamble could read as follows:

> "CPSM recognizes that all Canadians enjoy rights and freedoms under the *Charter of Rights and Freedoms*, including the freedom of expression, subject to reasonable limits. This Standard will set out reasonable limits for physicians using social media."

Definitions

We believe the definition of "disruptive behaviour" (contained in the proposed Standard as a footnote to Section 2.4.3) is worthy of its own paragraph, as in the CPSO Policy on Social Media. We believe it is a very instructive definition, as it highlights unacceptable behaviour but also contains a positive statement about the right of physicians to provide constructive criticism intended to improve patient care.

We expect that giving this definition more prominence may comfort physicians with concerns about how reasonable limits to expression will be determined.

Article 1 – Application

We note that Section 1.1 provides that the Standard applies to professional use of social media but can also apply to personal use. This depends upon several factors, including "the connection between the physician's conduct and their professional role".

We believe it would be useful to provide more explanation. What if a physician uses their name on social media but does not identify themself as a physician? What if a physician uses a name known only to friends and family? These choices should lessen the "connection" and would shield the physician from criticism for a broader range of posts than an "official" or "professional" social media profile.

Article 2 – Professionalism, Relationships and Boundaries

We are concerned about Paragraph 2.3, which requires physicians to anticipate the reaction of an increasingly volatile and outspoken public.

As we have stated, physicians are entitled to have varying views on many issues, including medical issues which may be the subject of intense debate in the public.

For example, recent events in the United States and elsewhere have once again put the question of reproductive health and rights into the forefront. While we have members who have devoted their lives to women's reproductive freedom and choice, and we also have members who, by reason of their religion or other reasons, have equally strong views against abortion.

Another topical example is the medical assistance in death (MAiD) regime. The federal government continues to struggle with how and when MAiD should be offered to those suffering from serious mental health issues. Physicians have a variety of views on the subject, and they should be free to express these views even if it is "reasonable" to assume that someone with a different view will be offended.

Another difficult area is with respect to measures respecting COVID. While physicians have been given ample information to make clear, evidence-based statements on public health measures including masks, social distancing, and vaccination, physicians have varying views about the costs and benefits of various measures, and should be able to express a range of opinions.

If a physician posting about any of these issues is not acting unethically by denigrating physicians, or others, who may take a different view, or otherwise offending the Code of Ethics, we believe the Standard must be flexible enough to allow for their individual expression. Otherwise, almost any statement might "reasonably" be perceived by those with opposing views as inappropriate.

"Conduct" could be viewed as going even further. A physician posting about being on vacation, enjoying a nice dinner, attending a sporting event, or supporting the ballet or theatre might draw the ire of someone who does not understand why physicians are not available 24/7. While this is an unreasonable perception, it is not unreasonable to expect that somebody will raise it.

Accordingly, we believe the last sentence of Section 2.3 should be amended to read "… and how their conduct might be perceived by a reasonable person." That might appear to be a modest amendment, but it changes it from a subjective test (is it even reasonable to predict how extreme or unfair someone in the public might be?) to a more objective test. Physicians should not have to limit their right to free speech because it might offend the unreasonable.

All of this is subject, of course, to the physician complying with the Code of Ethics and other areas of the Standards of Practice.

Section 2.4.5 requires physicians to consider the “power imbalance” between physicians and patients and the public. While this may be the case in many situations, on social media the power imbalance can often work the other way. An aggrieved patient, or a radicalized member of the public, has the almost unfettered freedom to say whatever they want about a physician, with the only recourse being an action for defamation which gives the unhappy party a larger soapbox. While it rarely justifies a physician engaging in a dispute on social media, and never justifies a physician revealing personal health information, physicians (like many other professionals and public figures) are not in a position of power when presented with hostile and/or defamatory social media posts.

Further, the Standard should never be interpreted in such as a way as to chill the ability of a physician to correct untrue (and potentially dangerous) statements being made by others on social media.

Article 3 - Privacy and Confidentiality

We have no concerns.

Article 4 - Communicating Medical Information

We believe Article 4.3 could be clearer. It is unclear whether the “above provisions” refer to the entire Standard, or just Article 4. Arguably, this could be seen as extending to any advocacy for system or societal change even if unconnected to medical information.

We suggest adding the words “health-related” before “advocacy efforts” would make this certain.

Enforcement

While not expressly set out in the Standard, we would like to discuss the response to potentially improper social media activity. As mentioned above, Doctors Manitoba does reach out to physicians should we have concerns.

Should the CPSM receive complaints about a member’s social media posts, we would hope the first action by the CPSM would be to ask the member to remove or take down any inappropriate posts. While we acknowledge that social media posts can be saved and republished by motivated individuals, this would be a “harm reduction” strategy to minimize concerns for the profession. In other cases, a controversial post could still fall within the Standard if it contains an acknowledgement stating it does not represent the majority or prevailing view of medical professionals.

In most cases, we believe that deleting or amending the posts should end the matter. Of course, if the posts have crossed the line from opinion or fair comment into otherwise prohibited behaviour (i.e. racist, misogynist, homophobic or transphobic content, inciting violence, denigrating another colleague, medical learner, staff, or patient, revealing personal health information, etc.), especially where there is evidence that the post has been broadly reported and repeated, that might lead to further action by the CPSM.

Contextual Information and Resources

We believe the bullet points are clear, concise, and valuable.

It might be useful also to remind members that their employment relationship or position may further limit their ability to communicate on social media. A post may not violate the Standard but that alone may not protect the member from disciplinary action.

It might also be useful to expressly remind physicians they are expected to adhere to all other standards, just as in any other potentially public space, and any advice or commentary related to medicine should be rooted in scientific evidence. Even if their comments are evidence-based, they continue to have a duty to refrain from abusive behaviours or other unbecoming conduct. Every physician has a role to preserve and building the public's trust in medicine.

It bears repeating that no one can assume anything posted to social media is private.

It is a minor issue, but libel (written statements) and slander (verbal statements) have been combined in Manitoba into the single action of defamation.

Thank you for the opportunity to provide this submission.

Yours truly,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

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February 28, 2023

Anna M. Ziomek, MD
TheRegistrar@cpsm.mb.ca

Dear Dr. Ziomek:

I am writing on behalf of the Honourable Audrey Gordon, Minister of Health, in response to your request for feedback of the College of Physicians and Surgeons of Manitoba's (CPSM) draft Standard of Practice for Social Media. Apologies for this late response.

We appreciate the opportunity to offer feedback. We have circulated this to various stakeholders and have not received any specific feedback or cautions. We trust that the CPSM has had the draft Standard reviewed by a legal expert specializing in professional liability and social media.

Social media has contributed greatly to timely communication and efficient distribution of information. It can also be used to disseminate inaccurate and damaging content. So we applaud the CPSM in setting these standards. We trust the Standard of Practice Social Media will be a meaningful and well received directive.

Sincerely,

Barb Wasilewski
Assistant Deputy Minister

c Honourable Audrey Gordon

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING
MARCH 22, 2023
FOR INFORMATION

SUBJECT: Strategic Organizational Priorities

BACKGROUND:

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

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

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

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

The Strategic Organizational Priorities for 2022/23 are:

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

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

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

Dr. Elliott will lead a discussion on this matter.

CPSM
STRATEGIC ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Prescribing Rules Review	21-Sep-21		Formed	1-Jun-23	1-Jul-23			**On Track**	Various Items are on the March Council Agenda for information. This is complex due to the number of Regulatory Bodies involved and the decision to implement almost all changes at one time rather than staggering changes over a period of time. It is intended for all materials to come to Council for approval for consultation at the June 2023 meeting.
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners	21-Sep-21		Formed					On Track	The Advisory Circle comtinues to meet in smaller subgroups to work on the following recommendations.
Statement & Apology	Approved by Council. Delivered to Assembly of Manitoba Chiefs and Manitoba Inuit Association. Working with Manitoba Metis Federation.							On Track	
CPSM Land Acknowledgement								Delayed	
Standard of Practice	Working on hiring an Indigenous Consultant to assist.							On Track	
Restorative Justice	Meetings held with University. CPSM staff attended a 3 Day workshop.							On Track	
Mandatory Training for Registrants	Decision to be forthcoming on which training to pursue at June Council meeting.							On Track	
Mentorship/Leadership								Delayed	
Definition of Indigenous-Specific Racism								Delayed	
Episodic Care, House Calls, Walk-Iin Clinics - Standard of Practice	21-Sep-21	21-Jun-21	Formed	22-Mar-21	22-Apr-21	22-Jun-21	1-Nov-22	Achieved	Council approved at September 2022 meeting with effective date of November 1, 2022
Quality of Care as Identity of CPSM	22-Jun-22				N/A	N/A		Delayed	Various initiatives have been undertaken to further this priority but not yet as an organized project.
Performance Metrics Creation	22-Jun-22			22-Mar-23	N/A	N/A		On Track	The Quality Department has prepared Performance Metrics which are being presented to Council in March 2023. Other departments are to follow.
Review of SofP/PD/Bylaws/Policies	22-Jun-22							On Track	This is ongoing over a 5 year period

Last revised: March 7, 2023

COUNCIL MEETING
MARCH 22, 2023
NOTICE OF MOTION

TITLE: Standard of Practice - Collaborative Care

BACKGROUND

Section 3 of the Standard of Practice – Collaborative Care require a consultant member to respond to a patient and member verbally or in writing to a request for a non-urgent consultation within 30 days of receipt of the request and notify the patient and the referring member of the anticipated appointment date. Issues related to compliance with Section 3 have been identified and it was determined that a working group should be established to review and enhance the Collaborative Care Standard of Practice.

The issue for Council is to determine competing priorities given potential capacity constraints.

Process to Choose Strategic Organizational Priorities

Council has established a number of Strategic Organizational Priorities for CPSM carrying out its legislative responsibilities and mandate to regulate the medical profession.

As part of the annual governance process, every June, Council chooses the Strategic Organizational Priorities for the upcoming year. This provides not only a disciplined approach to the process of choosing priorities, it also provides direction and accountability to staff on what priorities to pursue in the upcoming year. Last June Council chose the following Strategic Organizational Priorities:

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

The update of the Standards of Practice, Practice Directions, Policies, and Bylaws Multi Year Review was not included initially as a Strategic Organizational Priority. Council added this to the list last June. This has impacted resources and the delivery of other Strategic Organizational Priorities.

Council may wish to consider whether adding a new priority to the current list of Strategic Organizational Priorities may impact CPSM's ability to deliver current priorities, in addition to

delivering the ongoing operational tasks. As part of governance, it is appropriate to assess the impact on existing priorities, resources, operations, and capacity to achieve Strategic Organizational Priorities.

A Regulatory Impact Assessment is attached.

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

Further to Council's instruction to review a Standard of Practice for Collaborative Care please see attached CPSM Regulatory Impact Assessment for the Collaborative Care Standard review which includes the public interest and patient safety concerns.

Possible Questions for Councillors:

1. How will the insertion of work, associated with the Standard of Practice – Collaborative Care, impact tasks on current Strategic Organizational Priorities?

2. Does CPSM have the capacity to conduct work on the new proposed work prior to June 2023?

3. If this insertion of work negatively impacts existing resources and tasks for current Strategic Organizational Priorities what is the proposal to address competing priorities?

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 22, 2023, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the addition of the review of the Standard of Practice - Collaborative Care to the current list of Organizational Priorities.

CPSM Regulatory Impact Assessment

Review of Collaborative Care Standard

January 23, 2023:

Background/Issue:

The obligations of a consultant member require them to 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 - Collaborative Care Standard of Practice, s. 3.

CSC identified early in 2022 that there were issues related to compliance with Section 3 of the Collaborative Care Standard of Practice. It was also identified that Standard was silent on issues related to urgent/emergent consultations and that this may have contributed to patient harm due to lack of clarity around the responsibility of the referring and consulting physician in these time-sensitive situations. This prompted a review and reflection on the content of that standard and a request from CSC to Council that the standard be considered for review and updating. To assist in determining direction with respect to the standard, CSC launched a survey of the membership in July 202 to better understand reasons for or against compliance with specific aspects of section 3 of the standard. The response to the survey (attached) was significant in terms of number of respondents as well as the general sense that most respondents did not feel the timeline in 3.1 was reasonable due to system constraints, mainly access to administrative resources and procedure/surgical resources.

Dr. Ziomek and Dr. Mihalchuk, per instruction from Executive Committee took the matter to the Provincial CMO/ Shared Health Specialty Lead table for further discussion and feedback and it was reinforced that this aspect of the standard may be unreasonable in terms of expectation given current system challenges. Per discussion at the December Council meeting, it was decided that CPSM should proceed to build a working group to review and enhance the Collaborative Care Standard of Practice in its entirety.

Proposed Solution:

Form a working group with both specialists (urban and rural) and family physicians (urban and rural), public representation and key stakeholders from the health system (plus others identified as important) to review the current standard and revise/rewrite it to address identified deficiencies and perhaps unrealistic expectations. Dr. Mihalchuk has identified through the Provincial CMO/Shared Health Specialty Lead table some individuals who are interested in participating and supporting this work.

Accountability:

CPSM Registrar and Assistant Registrar (Quality)

Timeline:

TBD – will likely take 3-4 months of meetings for a draft for Council to review; then approval at Council for public and registrant consultation, revisions and finalization within 2-3 months of the consultation process.

There are significant operational and strategic organizational priorities which are currently consuming time and may make it more challenging to initiate this work before summer.

Fixed Timeframe

This is a fixed timeframe working group which would be disbanded once the final standard has been approved.

On-going Not Applicable ☒

Alignment of Organizational Priorities:

Improving this standard is a matter of patient safety. It is evident that the lack of direction around the expectations of consultants in urgent/emergent situations creates variability in response and this will have impact on the quality of patient care.

Where standards are set for physicians and they are unachievable, this puts CPSM in a position of being out of touch with the practice environment and can impact relevance and engagement of registrants with the core requirements of practice. This can then creep from one standard to another if physicians do not identify with or understand the reasons for requirements CPSM puts in place, especially if those expectations are unachievable. Council has identified engagement with registrants as a key priority as part of the rebranding of CPSM to be more intentional about our focus on maintaining and improving the quality of care.

This is not a Strategic Organizational Priority for 2022/23 and is not on the list for 23/24. The current Strategic Organizational Priorities for those years are:

- TRC: Addressing Anti-Indigenous Racism in Medical Practice
- Key Performance Metrics
- Creating Quality of Care as the Identity of CPSM

Patient Safety:

Timely communication around, access to and consistent approach to consultation is in the best interest of the public. Physicians need clear, achievable expectations especially in settings where timely acceptance, and ultimately timely delivery of specialty care is required. Improving the standard in terms of scope and direction will improve patient safety.

Risk Analysis:

Public Risk

There is no identified risk to the public in reviewing and updating the practice standard for Collaborative Care.

Reputational Risk

1) Public – for CPSM to identify gaps in their standard which may be impacting safe care, and not proceed to improve the standard would present a reputational risk to the organization in terms of its mandate to protect the public.
2) Registrants – for CPSM to identify aspects of a standard that may not be achievable but to continue to hold registrants to those standards would present a reputational risk to the organization in terms of engagement and relevance of the standard to registrants.

Regulatory Risk

The role of CPSM is to self-govern through a lens of protecting the public. This includes setting standards for medical practice that ensure a high quality of care and promote patient safety. The current gaps with this standard should be addressed to uphold the requirements of self-regulation in the medical profession.

Operational Risk

Adding another priority to CSPM staff and resources will have impact and may result in delays with other identified work already in progress (e.g., prescribing rules working group, TRC Advisory Circle work, metrics development, rebranding CPSM with a focus on quality of care). The more priorities, the greater the impact on staff and their time and decisions regarding what needs to be deprioritized may need to occur.

Regulatory Impact on Registrants:

A revised standard will change expectations for registrants. This may be seen positively or negatively depending upon the individual and the nature of the final changes. The registrant

consultation process for a new/revised standard is intended to provide an opportunity for registrants to engage and have a voice in influencing the final document.

Financial Impact:

Human Resources:

Working groups require administrative, staff, legal and Registrar support.
With some standards after implementation, there is a period of increased workload for staff related to supporting queries and supporting its socialization. The anticipated impact with this standard would be less than others (e.g., opioid standard).

Financial: Not Applicable ☐

Based on 12 working group members attending 4 working group evening meetings and a final meeting to finalize the Standard to go to Council, the budgeted amount would be as follows:
12 people X $175.00/meeting = $2,100.00 X 5 meetings = $10,500

CPSM Staff time to attend meetings (Admin Assistant, Assistant Registrar & Registrar and General Counsel) - $7,200

CPSM Staff time to re-write the standard - $5,200

TOTAL COST - $22,900

Infrastructure: Not Applicable ☒

Nil

Transition Budget: Not Applicable ☒

Nil

Alternatives or Status Quo:

Council could decide not to review the standard and leave the document as is until it comes up for review as part of the regular cycle.

Evaluation and Outcomes:

We would follow the usual process to gauge response to a revised standard through feedback and outreach from the public and registrants.

Additional Information:

Not Applicable ☒

Recommendation:

Council has recommended CPSM address the Collaborative Care as a strategic priority and proceed with a working group.

Submitted by:

Dr. Ainslie Mihalchuk – Assistant Registrar (Quality)

COUNCIL MEETING – MARCH 22, 2023
COMMITTEE REPORTS
FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met in person, with a few members joining virtually, March 1, 2023. The majority of matters discussed at the meeting appear on this Council agenda.

An Appeal Panel met on January 4, 2023, to hear four Investigation Committee appeals.

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

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

1. Audit RFP
   - Management presented the preliminary plan and targeted firms for the upcoming RFP for Audit services. Management is planning to issue the targeted RFP in March in order for a recommendation to be made to the May 30, 2023 FARMC.
   - Due to the timing of this years audit, a special meeting will be held in the third week of June to review the audited financial statement and prepare a motion for the June 27 Annual General Meeting.

2. 3rd Quarter Financial Statements - 2022-23 Fiscal Year
   - Management presented the CPSM financial statements for the 9 months ending January 31, 2023.
   - CPSM is reporting a $390,000 favorable variance in comparison to the budget. The positive variance is primarily due timing issues on the operational expense side, unanticipated cost recoveries and higher than anticipated revenue from documentation fees and interest on investments.
   - The year end forecast is estimated to be approximately a $400,000 deficit which is an improvement from the originally projected $787,000 deficit.

3. Enterprise Risk Management
   - Management will be adding an additionally meeting to the FAMRC calendar. A September meeting will be added that will focus the risk management activities of CPSM.
4. IT Security
   - The IT security summary and roadmap was presented to the committee. CPSM continues to improve it's security score with a goal to remain in the top 25% of organizations of similar size.

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

PROGRAM REVIEW COMMITTEE REPORT:

Diagnostic Facilities:

- MANQAP plans to inspect a small sampling of Physician Office Laboratories to address the double standard that exists between Patient Service Centres (MANQAP inspected) and Physician Office Labs (not MANQAP inspected) where the same diagnostic tests are being performed. MANQAP will use the current patient service centre standards for these inspections and the findings will be brought to Program Review Committee.

Non-Hospital Medical Surgical Facilities:

- A process has been developed with MB Health to ensure that non-hospital medical surgical facilities (NHMSF), which have been awarded surgical procedures through the MB Health Request for Supply process to reduce surgical wait times, have been accredited by MANQAP.

- Legal Counsel advised MANQAP that a physician/surgeon who performs procedures at a NHMSF which is under an APO review or inspection and feels they are able to act in public interest, may not have a significant conflict of interest to exclude them from participating in adverse patient outcomes or inspections. An advertisement has been posted on the CPSM website to help recruit additional NHMSF consultants for the certain area of practice.

Respectfully submitted
Ms Leanne Penny
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

The Complaints Committee meetings were held on **January 10, 2023 and February 7, 2023**

On January 10, 2023 CC reviewed 15 matters. The outcomes of these investigations were as follows:

2 cases resulted in a letter of criticism
3 cases resulted in a letter of advice
9 cases resulted in a decision that no further action was required
0 cases resulted if endorsement of an informal resolution
1 case resulted in a referral to the Investigation Committee

On February 7, 2023 CC reviewed 14 matters. The outcomes of these investigations were as follows:

1 cases resulted in a letter of criticism
10 cases resulted in a letter of advice
2 cases resulted in a decision that no further action was required
1 cases resulted if endorsement of an informal resolution
0 case resulted in a referral to the Investigation Committee

Respectfully submitted
Dr. Norman McLean
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

Dear Council Members,

The Investigation Committee has met twice since our last council meeting.

On January 11th, we reviewed 12 matters. As a result of those discussions, we had 8 decisions that resulted in criticism or advice, 2 that resulted in no further action, 1 that we requested an undertaking for education and one case was deferred to February as the committee wished further clinical information to help reach its decision.

On February 15th we reviewed 12 matters. 8 of those resulted in criticism or advice and 4 we deemed to require no further action.

We are meeting again on March 15th to review a further 14 matters.

Please let me know if anyone has any questions.

Respectfully submitted
Dr. Kevin Convery, Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

Central Standards Committee (CSC) Activities 2023

The CSC met January 27, 2023

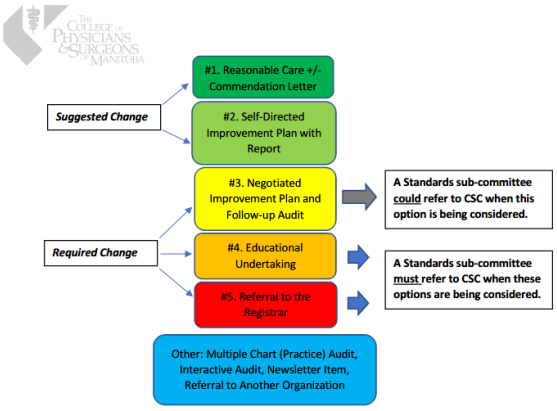
AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2023

The CSC reviewed:

- 3 Age Triggered Audits
- 5 Referred Audits

The following outcomes were determined at CSC.

	#1 Outcomes
5	#2 Outcomes
2	#3 Outcomes
1	#4 Outcomes
	#5 Outcomes
	Other – Interactive Audit
8	Total outcomes



Standards Sub-Committee Reporting.

The Central Standards Committee has been receiving quarterly and annual reports from the various Standards Committees within the province.

Dr. Ainslie Mihalchuk and Dr. Roger Süss had individual meetings with the Chairs of the WRHA and Southern Health in December 2022 and January 2023.

The following table lists currently active and non-active committees as listed in Schedules A, B, C, D of the Central Standards By-Law:

Committee (Active)	RHA	Chair	Current Status
Interlake-Eastern ASC	Interlake-Eastern	No Chair	Dr. Mihalchuk and Dr. Penner CMO for IERHA had a discussion in December. Committee will resume when a new Chair has been found.
Selkirk ASC	Interlake-Eastern	Dr. Ian Alexander	Emailed Dr. Alexander for Q1, Q2, Q3 reports, Oct. 17, 2022. Reminder sent Jan. 16. Reminder sent Feb. 17.
Northern ASC	Northern	Dr. Shadi Mahmoud	2022 Q4 and Annual Report required. Reminder sent Jan. 16. Reminder sent Feb. 17. Reminder sent Mar. 2.
Brandon Regional Health Centre ASC	Prairie Mountain	Dr. Nicolaas Butler	Committee recently re-activated. Minutes received in old format. Committee has been updated with the new quarterly report templates.
Prairie Mountain Health ASC	Prairie Mountain	Dr. Shannon Prud'homme	Up to date.
Brandon Regional Health Centre Psychiatry	Prairie Mountain	Dr. Gilbert Lee	Committee is on hold due to lack of psychiatrists in Brandon.
CancerCare	Provincial	Dr. Catherine Moltzan	Up to date.

Endoscopy Provincial	Provincial	Dr. Ross Stimpson	Up to date.
Orthopedic Surgery Provincial	Provincial	Dr. Eric Bohm	Up to date.
Portage ASC	Southern	Dr. Jim Ross	Up to date.
Southern ASC	Southern	Dr. Shayne Reitmeier	No reports yet. Dr. Reitmeier was just approved as Chair at the January 2023, CSC meeting.
Boundary Trails Health Centre	Southern	Dr. Kevin Convery	2022 Annual Report required. Reminder sent Jan. 16. Reminder sent Feb. 17. Reminder sent Mar. 2.
C.W. Wiebe Medical Centre	Southern	Dr. Louw Greyling	Up to date.
Eden Mental Health Centre	Southern	Dr. William Miller	Up to date.
Winnipeg Regional Health Standards Committee	WRHA	Dr. Elizabeth Salamon	Up to date.

Committee (Inactive)	RHA	Chair	Current Status
Altona Community Memorial Health Centre	Southern	**Unknown**	Southern Health is currently restructuring. A new Chair, Dr. Shayne Reitmeier was approved at the previous CSC meeting in January 2023 and will be working with the hospital/health centers indicated in this section to re-activate standards committee activities.
Bethesda Hospital (Steinbach)	Southern	**Unknown**	
Carmen Memorial Hospital	Southern	**Unknown**	
Gladstone Health Centre	Southern	**Unknown**	
Morris-Emerson	Southern	**Unknown**	
St. Claude, Notre-Dame-de-Lourdes, Trehern	Southern	**Unknown**	
Ste. Anne Hospital	Southern	**Unknown**	
Vita & District Health Centre	Southern		
Selkirk Mental Health Centre	Interlake-Eastern	**Unknown**	Chair unknown.

Respectfully submitted
Dr. Roger Suss, Chair
Central Standards Committee

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 22, 2023

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

CPSM STATEMENT AND APOLOGY ON TRUTH AND RECONCILIATION AND INDIGENOUS-SPECIFIC RACISM IN MEDICAL PRACTICE

On January 31 CPSM delivered the Statement and Apology to the Assembly of Manitoba Chiefs at their Special Meeting on Health Legislation and UNDRIP. All Chiefs were gathered in a three-day meeting, and had staff and others in attendance, for maybe 125 in the room. CPSM could not have imagined a more impressive occasion! The CPSM Statement and Apology was delivered in person to the Assembly of Manitoba Chiefs by Dr. Jacobi Elliott (President), Dr. Ira Ripstein (Past President), and myself. We tried to deliver it with the greatest of humility and sincerity. Based upon the formal comments afterwards it was quite impactful. The Grand Chief Cathy Merrick stated her heart was broken reflecting how the medical profession had treated her people but was pleased with what CPSM had said. Many other Chiefs genuinely thanked the three doctors, commended what they had to say, and said that they welcome the changes, and will watch for changes. So while words are important, the follow-up actions are even more important. As the AMC news release states – "cautious optimism".

On February 27 CPSM delivered the Statement and Apology to the Manitoba Inuit Association. Again, the delivery was quite impactful for both the physicians and the members of the Manitoba Inuit Association. The Association has asked for a framed copy of the Statement and Apology. The Manitoba Inuit Association thanked CPSM and questioned whether CPSM will be delivering the Apology to those patients living in the communities, who have been affected by the racism in medical practice.

CPSM is working with the Manitoba Metis Federation to deliver the Statement and Apology.

It is very important for CPSM to continue working on this initiative as change and improvement are required in the delivery of medical care by individual registrants. Meeting with these organizations has impressed upon me just how important this is as a priority.

STAFF MATTERS

The information described below highlights staffing changes and additions that are known to be occurring in the 2023.

Reception - A receptionist has resigned. CPSM is restructuring the reception resources and allocating the funding from this vacancy to the Complaints and Investigation department to hire

an additional Administrative Assistant. Complaints volumes continue to rise. Reception is not expected to be adversely impacted due to recent automation and part-time students.

Executive Office - Mr. Mike Triggs has started in his role as General Counsel effective February 27. Ms Kathy Kalinowsky will be providing orientation and transitioning support to Mr. Triggs over the month of March after which Ms Kalinowsky will be providing short-term support for the Quality Prescribing Rules Review Working Group, slated for June Council, as well as support to the Truth and Reconciliation Advisory Circle with the work CPSM is undertaking.

Ms. Lynne Leah has announced her upcoming retirement, effective April 28, 2023. Lynne has been with CPSM for almost 17 years in many different roles. Lynne's current role involves supervising the reception area, coordinating human resources, payroll and benefits as well as provides administrative support for the Prescribing Practices Program.

Manitoba Quality Assurance Program – CPSM has engaged a recruitment firm to assist with the recruitment of a Director for MANQAP. The initial search did not result in suitable candidates. The current Director, Dr. Ian Wilkinson, has agreed to stay on until the end of March to assist with the continuity of the program and potential transition.

Complaints and Investigation – Due to increasing volumes CPSM is recruiting for additional Medical Consultant resources (2 positions @ 0.4 EFT) and will be hiring an additional Administrative Assistant through the reallocation of funding from the reception area.

MEETINGS ATTENDED - OTHER ORGANIZATIONS

Provincial CMO/Speciality Lead Meeting – January 5, February 2, and March 2, 2023

Participated in Grand Rounds Psychiatry regarding MAiD and Mental Health – January 10, 2023

Medicine Subcommittee of Joint Council – January 16, February 15, 2023

PGME Executive Committee – January 17, 2023

Presented Regulation Governance talk to Med I Students – January 24, 2023

Participated in webinar with Public Health on Syphilis outbreak – February 7, 2023

Participated in College of Licensed Practical Nurses Reserved Acts Consultation with CLPN and Government – February 13, 2023

Shared Health Medical Advisory Committee – February 23, 2023

Federation of Medical Regulatory Authorities of Canada (FMRAC)

- Board Meeting – January 17, 2023
- Board Retreat – March 6 & 7, 2023

MEDIA

CPSM responded to local and national media inquiries on various topics including virtual medicine fees, impacts of misinformation on medical regulators, legislation for publicizing terms and conditions of registrants, and questions stemming from a case where a patient filed a lawsuit against a cancelled registrant.

In the interest of being transparent and providing education to the public, responses were provided where applicable (and not prohibited by legislation).

Media coverage this quarter included:

- **Fast-Track Registration**: 680 CJOB (radio), CTV News Winnipeg (TV), and Winnipeg Free Press (print and online)
- **Statement and apology for racism in medical care,** delivered at the Assembly of Manitoba Chiefs Special Meeting – coverage included CBC News, CTV News, Firstnations.ca, Turtle Island News
- **Inquiry decision** regarding Dr. Ahmed Naseer Warraich
- **Disciplinary actions** against Dr. Shamoon Din

COMMUNICATIONS

- December newsletter communicated guidance on diagnosing Charcot foot, Pulmonary Embolism and Oral Contraceptives, retiring or leaving your practice, Quality Improvement Update and year-end messaged from the Registrar, Council President, and the Dean.
- January newsletter including information on public consultation, M3P update, addressing the STBBI outbreak, MCCQE1 elimination for International Medical Graduates,
- Fast-Track Registration was announced.
- Email from the Registrar acknowledging Resident Doctor Appreciation Week (Feb 6-10, sent to resident registrants).
- A joint webinar with Manitoba Health on syphilis was held in early February.
- Standard of Practice for Social Media public consultation held for registrant, stakeholder, and public feedback.
- Issued Statement and Apology on Indigenous-specific racism in medical practice to First Nations and Inuit leaders.

FINANCE

Finance completed an interim audit in January 2023. No significant issues were identified in the audit. The remainder of the Finance updates can be found in Finance Audit and Risk Management Committee update to Council.

INFORMATION TECHNOLOGY

The IT Department recently received an update from our IT partner, Broadview, regarding our current security. CPSM continues to make headway in improving our Centre for Internet Security (CIS) score. CPSM is following a rigorous process that will continue to see security enhancements implemented both in the short and long-term.

Portal Enhancements
The IT Team has been working with the Registration Department on converting the contracts of supervision to an electronic version. Testing is currently underway and the new process should be fully implemented in the next few weeks.

The IT Team implemented two security enhancements to the Portal; multifactor authentication for CPSM staff, and advanced activity logging.

QUALITY DEPARTMENT

Physician Health Program

- Since December 1, 2022, the PHP has had 20 referrals to the program, bringing the total for the year to 82
    - 9 of those referrals are low level
    - 9 are considered moderate level
    - 2 are high level referrals
- The program currently has 43 registrants with active undertakings
- There are 67 active registrants (caseload) within the program (24 are exclusive of undertakings)

MANQAP

- **Diagnostic Facilities:**
    - MANQAP plans to inspect a small sampling of Physician Office Laboratories to address the double standard that exists between Patient Service Centres (MANQAP inspected) and Physician Office Labs (not MANQAP inspected) where the same diagnostic tests are being performed. MANQAP will use the parts of the current patient service center standards for these inspections and the findings will be brought to Program Review Committee.

- **<u>Non-Hospital Medical Surgical Facilities:</u>**
    - A NHMSF Annual Review Report template has been developed and was sent to NHMSFs in December 2022 for their review and sign off. All reports have been returned to the MANQAP office. The NHMSF requires facilities to report on the following (as outlined in the CPSM Accredited Facilities Bylaw):
        - The exact number and types of procedures performed in the facility
        - The exact number and type of adverse outcomes and events
        - Assurance that quality assurance and quality improvement programs initiatives in the facility sufficient to demonstrate the standards of care set by CPSM and required for good medical care.
        - List of members with privileges and health care staff
        - List of members whose privileges were not renewed or suspended or revoked with details.
- MANQAP has been working to ensure NHMSFs have current approved procedure lists. This has occurred by doing the following:
    - A process has been developed with MB Health to ensure that non-hospital medical surgical facilities (NHMSF), which have been awarded surgical procedures through the MB Health Request for Supply process to reduce surgical wait times, have been accredited by MANQAP.
    - NHMSFs have been asked to verify their current approved list via their annual report.

Quality Improvement Program

- Program operations continue at a normal pace
- Work plan being finalized to meet the end of the first QI Program cycle which ends in December 2025
- Anticipate program operations to be available to registrants through CPSM portal later in 2023 – will streamline process for participants and staff
- Auditor Training Workshop planned for May 19, 2023. Attendees being accepted based on CPSM needs/gaps – across all audit programs
- Continued expansion into different specialty areas year by year
- QI Program reports to Central Standards Committee – process going smoothly
- QI staffing has doubled to two full time administrative staff and two 0.6 EFT medical consultants to enable meeting the timeline as outlined in the RHPA. New staff are functioning well in the team.

Standards Audits and Monitoring

- The Age Triggered Audits Program will begin reporting cohorts by year of birth instead of previously reporting by age. There are currently several cohorts in various stages of the audit process within this program. The goal is to reach a single cohort which is to initiate registrants that are or will be 70 years old by 2030. At this current rate of initiating audits, we should achieve this goal well before the year 2030.
- Referred audits continue to be processed and completed as received

- New reporting by year of birth and quarters is in development
- Total qualifying audits for 2023 is **121**, which includes:
    - **6** YOB: 1947 (76 yrs) & 1946 (77 yrs) - (Carried over, challenging to audit)
    - **15** YOB: 1948 (75 yrs) - (Newly initiated)
    - **12** YOB: 1949 (74 yrs) - (In Progress)
    - **21** YOB: 1950 (73 yrs) - (In Progress)
    - **24** YOB: 1951 (72 yrs) - (Initiate in the last half of 2023)
    - **21** Repeat Age Triggered (In progress and to be initiated throughout 2023)
    - **17** Repeat Referred (In progress and to be initiated throughout 2023)
    - **5** New Referrals (In Progress)

Prescribing Practices Program

- **Registrant/Health Professional Inquiries**: Since December 2022, responded to 27 general prescribing advice inquiries (total 103 GPA cases in 2022) and 30 OAT mentoring cases (total 118 OATM cases in 2022).
- **Methadone & Suboxone**: Issued 41 OAT prescribing approvals since December 2022 (39 for Suboxone only under new Practice Direction) and 2 pain/palliative care methadone approvals in Q1. OAT Recommended Practice Manual to be complete by Q2.
- **CME Death Review**: Since December 2022, 25 ME cases reviewed with registrant communication completed. 10 registrants identified for Secondary Review (≥3 concerning cases within 36 months); 1 completed in December 2022 and several reviews pending concurrent registrant involvement with other CPSM departments.
- **Ketamine Project**: 60 registrants surveyed re: case-specific ketamine prescribing to determine if further regulatory guidance is needed (final response rate ~60%). Data compiled for detailed analysis in Q2-Q3 2023.
- **Quality Prescribing Review Working Group**: Attending meetings, assisting with revisions to relevant Practice Directions and Standards of Practice, and responding to registrant inquires as changes are rolled out. Tracking specific data re: M3P-related inquires.
- **Collaboration**: Joined meeting with community advocates for Safer Supply (MySafe) Pilot Project in Winnipeg, in response to overdose crisis. Collaborating with other regulators on a Companion Guide for Joint Practice Direction on Rural, Remote, and Underserved Populations; survey of individuals working with these populations planned for Q2-Q3.

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The department continues to experience high volumes of complaints and looks forward to additional personnel, as noted above. As always, priority is given to addressing serious matters of public safety and staff are working diligently to bring matters to the Committees as soon as possible without compromising quality.

Current number of open matters:

Investigations – 150

Complaints – 120
Resolution by Communication – 22

Upcoming Inquiry Hearings: 1

Dr. Bullock Pries and Ms Jocelyne Ritchot (legal counsel), along with Dr. Ainslie Mihalchuk, recently attended a 3-day seminar in Washington DC regarding the principles of Restorative Justice in Medicine, a practice rooted in Indigenous tradition that works toward addressing harm and resolving conflict. Utilizing this approach in appropriate cases will align with CPSM's goals of increased informal resolution and would be especially helpful in addressing harm to Indigenous patients. Pursuing this approach to complaints and investigations is one of the recommendations of the TRC Advisory Circle.

REGISTRATION DEPARTMENT

The 2022 Registration Review Report by the Fair Registration Practices Office has been finalized. Registration reviews are conducted at times specified by the director of fair registration practices.

Manitoba's fairness legislation was amended in December 2021. This review was primarily restricted to the consideration of compliance regarding 3 new duties in the Fair Registration Practices Code:

- A duty that assessment criteria be necessary – FRPO has no concerns with the reasonableness and necessity of CPSM's assessment criteria and requirements for registration.
- A duty to abide domestic trade agreements – FRPO states that CPSM is not fully compliant with provisions set out in the Canadian Free Trade Agreement and the New West Partnership Trade Agreement as we require mobility applicants to provide a Certificate of Professional Conduct from each jurisdiction in which they currently are or were authorised to practice medicine or any other regulated profession or occupation. Under the CFTA and NWPTA, it is not permissible for a regulatory authority to ask a mobility applicant to provide evidence of good standing from a jurisdiction where they were previously, but are no longer, certified. FRPO understands CPSM asks mobility applicants for a Certificate of Professional Conduct and that this request is meant to seek evidence of good character, not standing.
- Duty to notify FRPO regarding changes in assessment and registration practice – CPSM is in compliance with this duty.

Fast Track Registration became active in January 2023. To date, 4 applications have been received and out of those 4, 2 have been registered. The other 2 have completed the documentation but are not starting until summer. Feedback has been very positive.