September 2022 Council Meeting

Thursday, September 29, 2022 | 8:00 a.m. |

AGENDA

CPSM Office – Brown Room (In Person)
1000 – 1661 Portage Avenue

	Time	Item		Action		Page #
8:00 am	5 min	1.	Opening Remarks		Dr. Elliott	
8:05 am	0 min	2.	Agenda – Approval	For Approval	Dr. Elliott	
8:05 am	0 min	3.	Call for Conflict of Interest			
8:05 am	5 min	4.	Consent Agenda i. Council Meeting Minutes – June 22, 2022 ii. Practice Ready Assessment – Fields of Practice Additions iii. Standard of Practice – Seatbelt /Helmet Exemptions iv. Standard of Practice - Female Genital Cutting/Mutilation	For Approval	Dr. Elliott	4 5 9 10 13
8:10 am	30 min	5.	Standard of Practice – Episodic Visits, House Calls, and Walk-in Primary Care	For Approval	Ms Penny Mr. Barnes Ms Kalinowsky	16
8:40 am	20 min	6.	Standard of Practice - Virtual Medicine	For Approval	Dr. Elliott Ms Kalinowsky	32
9:00 am	30 min	7.	Truth & Reconciliation Commission: Addressing Indigenous Racism in Medical Practice – Advisory Circle Recommendations	For Approval	Dr. Monkman Dr. Ziomek	52
9:30 am	30 min	8.	Truth & Reconciliation Commission: Apology and Statement	For Approval	Dr. Monkman Dr. Ziomek	63
10:00 am	20 min	9.	Break			
10:20 am	45 min	10.	Registration Department Overview	For Information	Ms Stevenson	68
11:05 am	15 min	11.	Fast Track Registration	For Information	Dr. Ziomek Ms Stevenson	80

	Time	Item		Action	Presenter	Page #
11:20 am	10 min	12.	Strategic Organization Priorities	For Information	Dr. Ziomek Ms Kalinowsky	85
11:30 am	10 min	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		91
11:40 am	20 min	14.	Registrar's Report	For Information	Dr. Ziomek	95
12:00 12:30 pm	30 min	15.	In-Camera – with Registrar In-Camera – Council Only Review of Evaluation of Council			
4 hrs 30 min			Estimated time of sessions			

Regulated Health Professions Act

Duty to serve the public interest

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

CPSM Mandate

10(2) A college has the following mandate:

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

CPSM Governance Policy – Governing Style and Code of Conduct:

1.1 General

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

COUNCIL MEETING –SEPTEMBER 29, 2022
CONSENT AGENDA
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Consent Agenda**

BACKGROUND:

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

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

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

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

i. Council Meeting Minutes – June 22, 2022
ii. Practice Ready Assessment – Fields of Practice Additions
iii. Review of Standard of Practice – Seatbelt/Helmet Exemptions
iv. Review of Standard of Practice – Female Genital Cutting/Mutilation

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

All items on the consent agenda are approved as presented.

1000 – 1661 Portage Avenue, Winnipeg Manitoba R3J 3
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MINUTES OF COUNCIL

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on June 22, 2022 in person.

1. CALL TO ORDER

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

COUNCILLORS:
- Ms Leslie Agger, Public Councillor
- Mr. Chris Barnes, Associate Member
- Dr. Kevin Convery, East
- Dr. Jacobi Elliott, President
- Mr. Allan Fineblit, Public Councillor
- Ms Lynette Magnus, Public Councillor
- Dr. Norman McLean, Winnipeg
- Ms Marvelle McPherson, Public Councillor
- Dr. Lisa Monkman, North
- Dr. Charles Penner, West
- Ms Leanne Penny, Public Councillor
- Dr. Brian Postl, University of Manitoba
- Dr. Ira Ripstein, Past President
- Dr. Nader Shenouda, President Elect
- Dr. Roger Süss, Winnipeg - Virtually

STAFF:
- Dr. Anna Ziomek, Registrar
- Dr. Ainslie Mihalchuk, Assistant Registrar
- 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 attended for Item 5

REGRETS:
- Ms Dorothy Albrecht, Public Councillor
- Dr. Caroline Corbett, Winnipeg
- Dr. Mary Jane Seager, Winnipeg

GUESTS:
- Dr. Wayne Manishen – Virtually
- Ms Katrina Clarke, Winnipeg Free Press – Virtually
  8:00 to 10:30

2. ADOPTION OF AGENDA

IT WAS MOVED BY MR. ALLAN FINEBLIT, SECONDED BY MS LYNETTE MAGNUS:
CARRIED:

That the agenda be approved as presented.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

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

4. CONSENT AGENDA

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

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

- Council Meeting Minutes – March 23, 2022
- Reappointment of Ms Magnus to Council
- Financial Management Policy
- Fee Bylaw

5. PRESCRIBING PRACTICES PROGRAM UPDATE PRESENTATION

Dr. Marina Reinecke presented how the CPSM Prescribing Practices Program improves patient safety by increasing safe prescribing of certain drugs that can be abused. Council strongly supports the educational work of the Prescribing Practices Program in improving patient and public safety.

6. STRATEGIC ORGANIZATIONAL PRIORITIES

Council endorsed the newly developed governance process to set strategic organizational priorities. Council directed these priorities for 2022/23:

- 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

Council also directed that the following FMRAC initiatives no longer be considered as CPSM Strategic Organizational Priorities:

- Streamlined Registration – Fast Track Application
- Portable License
- Artificial Intelligence
- Telemedicine/Virtual Medicine

7. OPERATING BUDGET & FEES 2022/23

The three-year proposed budget is forecast to provide:

- a balanced budget by 2024/25;
- Adjusted fees on specific categories where revenues do not match workload/expenses;

- Adjusted fee categories that have not previously been adjusted by CPI;
- Address potential cross subsidization of the physician certificate of practice fee to other categories;
- Utilize CPSM's unrestricted reserve to assist in minimizing fee increases.

IT WAS MOVED BY DR. NADER SHENOUDA, SECONDED BY DR. KEVIN CONVERY:
CARRIED

1. Council approve the 2022/23 annual operating budget as presented.
2. Council approve the following registrant fee increases for membership year 2022-23:
   a. For the annual certificate of practice of Full Practicing, Provisional, and Assessment Candidate Registrants, additional 2% increase of $40 for a final amount of $2,050;
   b. For the annual certificate of practice of Regulated Associate Registrants – Physician Assistant, an increase of $100 for a final amount of $400;
   c. For the annual certificate of practice of Regulated Associate Registrants – Clinical Assistant, an increase of $100 for a final amount of $400; and,
   d. For the annual Medical Corporation Fee, an increase of $50 for a final amount of $200.

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

Ms Penny and Ms. Kalinowsky provided a summary of the feedback received from the recent consultation of the draft Standard of Practice. Changes will be made to the Draft Standard of Practice and final approval will be sought from Council.

9. APPOINTMENT TO COMMITTEES

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

That Committee membership for the 2022/23 year be approved as per attached charts.

10. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

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

11. REGISTRAR/CEO'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, including questions on equity, diversity, and inclusion.

12. IN CAMERA SESSION

An in-camera session was held and the President advised that there was nothing to report.

There being no further business, the meeting ended at 11:55 p.m.

_____

Dr. J. Elliott, President

_____

Dr. A. Ziomek, Registrar

COUNCIL MEETING – SEPTEMBER 29, 2022

CONSENT AGENDA ITEM

SUBJECT: Approval to include Cardiac Surgery, Palliative Care, Plastic Surgery, Neurosurgery, Rheumatology, Thoracic Surgery, and Vascular Surgery Fields of Practice for Assessment for the Purposes of CPSM General Regulation Section 3.38(b).

BACKGROUND:

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

If Council approves the addition of the fields of Medicine to the Specialist Field of Practice for Assessment, a physician can be referred to the Division of Continuing Professional Development for an assessment in that area. Dr. Reslerova, the Director of the International Medical Graduate Program has confirmed in writing that the Section Heads of Rheumatology (Dr. Preschken), Neurosurgery (Dr. McDonald), Section Head Adult Palliative Care Medicine (Dr. J. Pilkey), and Department of Surgery (Dr. E. Buchel) have committed to participate in the Practice Ready Assessment of physicians who are seeking registration with CPSM.

There are now applicants for the above Specialities. In most cases the applicants practiced medicine independently and have been registered as specialists in this area of practice in another jurisdiction outside Canada. All applicants must have successfully passed the examinations to be a Licentiate of the Medical Council of Canada.

PUBLIC INTEREST RATIONALE:

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

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Cardiac Surgery, Palliative Care, Plastic Surgery, Neurosurgery, Rheumatology, Thoracic Surgery, and Vascular Surgery be added to the Qualifications and Registration Practice Direction as a Specialist Field of Practice for Assessment for the purpose of CPSM General Regulation Section 3.38(b).

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – SEPTEMBER 29, 2022

CONSENT AGENDA ITEM

TITLE: **SEATBELT/HELMET EXEMPTIONS – STANDARD OF PRACTICE**

BACKGROUND:

Council has directed that CPSM undertake a multi-year review of the Standards of Practice, Practice Directions, and Policies.

The Standard of Practice Seatbelt/Helmet Exemptions was reviewed by CPSM staff. It was also reviewed by Manitoba Public Insurance Corporation (MPIC), who indicated they were supportive of the existing Standard. It is recommended that no changes be made to the substance of the Standard. Both helmet and seatbelt usage are mandatory under the *Highway Traffic Act*.

The Standard has simply been re-organized slightly to conform to the current format for Standards of Practice. Please see attached Standard.

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 following is taken from the MPIC website to demonstrate the importance of seatbelt and helmet *usage for public safety:*

> ***Seatbelts***
>
> ***You're not a dummy. Wear your seatbelt.***
>
> *In a collision, being ejected from a vehicle is almost always deadly. Your seatbelt is what keeps you in your seat. Being buckled up during a crash can save your life and prevent serious injury. In fact, taking five seconds to buckle up reduces the risk of being killed in half.*
>
> ***Seatbelt penalties and fines***
>
> *In Manitoba, wearing your seatbelt is a law and you can be penalized for not wearing it. We have one of the highest fines in the country* ***($300 and two demerits)*** *against unbelted drivers. A driver can also be ticketed $299.65 for each passenger under the age of 18 who is not properly buckled up, either with a seat belt or in a child car seat. Passengers 18 years and over can be ticketed similarly for not buckling up.*

Always wear a helmet

Proper riding gear is the only personal protection a rider has against the natural elements and in case of a collision. A helmet is your only protection against a serious or fatal head injury. Select one that permits the use of prescription lenses if required. Your helmet should be routinely inspected for cracks or damage that may make it useless in a collision.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

Council approves the proposed changes to The Standard or Practice – Seatbelt/Helmet Exemptions as per attached document.

Standard of Practice

Seatbelt/Helmet Exemptions

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

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

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

~~Since reconfiguration of the seatbelt, the use of padding, or other accommodations are available and acceptable alternatives to non-use of a seatbelt or helmet assembly, and since there are no medical conditions that justify exemptions from using a seatbelt or helmet assembly, a registrant must not write a seatbelt or helmet exemption.~~

1. There are no medical conditions that justify exemptions from seatbelt or motorcycle helmet use.

2. A member must not provide a seatbelt or motorcycle helmet exemption.

COUNCIL MEETING – SEPTEMBER 29, 2022

CONSENT AGENDA ITEM

TITLE: Standard of Practice – Female Genital Cutting/Mutilation

BACKGROUND

A Strategic Organizational Priority is the ongoing review of the Standards of Practice and Practice Directions.

The Standard of Practice for Female Genital Cutting/Mutilation was reviewed. A jurisdictional scan indicated that colleges in Ontario and Nova Scotia have similar standards, but Saskatchewan, Alberta, and British Columbia do not have any such standard. The Standard has been revised to include a preamble to provide a greater understanding of the need for the Standard and a reference to a Clinical Practice Guideline, in the Contextual Information and Resources section, is provided to assist registrants in providing for advice and providing medical care to such patients. Revisions are in red.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

> Council approves the proposed changes to The Standard or Practice – Female Genital Cutting/Mutilation as per attached document.

Standard of Practice

Female Genital Cutting Mutilation

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

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

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

PREAMBLE

Female genital cutting/mutilation is internationally recognized as a harmful practice that results in the violation of human rights. Many international and national bodies including the World Medical Association, and the Society of Obstetricians and Gynecologists of Canada have released statements opposing the practice and participation of physicians in FGC/M.[1]

1. Female genital cutting/mutilation (FGC/M) is the excision, infibulation or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person, which may result in complications with voiding, sexual function, and psychological wellbeing. The *Criminal Code of Canada* categorizes FGC/M as aggravated assault with certain exceptions, and FGC/M on a minor is child abuse and must be reported to the appropriate child caring agency pursuant to *The Child and Family Services Act.*
2. Registrants must not perform FGC/M.
3. Registrants must not refer any patient to any other person for FGC/M.
4. If a registrant learns of another registrant performing FGC/M, the registrant must immediately report the matter to CPSM.
5. Registrants must be mindful of the legal obligation to report child abuse to the appropriate child caring agency pursuant to *The Child and Family Services Act.*

[1] WMA Statement on Female Genital Mutilation and Society of Obstetrics and Gynecology of Canada's Clinical Practice Guideline No. 395 – Female Genital Cutting.

CONTEXTUAL INFORMATION AND RESOURCES

Registrants play an important role in opposing and denouncing FGC/M. Registrants can support patients by educating themselves on how to properly manage possible complications related to FGC/M and by providing culturally sensitive counselling to families about the danger of the practice. Registrants who encounter patients who have undergone FGC/M can obtain guidance from the Society of Obstetrics and Gynecology of Canada's Clinical Practice Guideline No. 395 – Female Genital Cutting.

COUNCIL MEETING - SEPTEMBER 29, 2022

NOTICE OF MOTION

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

BACKGROUND

The following was provided to Council at its meeting in June 2022:

"At its June 2021 meeting, Council established its upcoming Strategic Organizational Priorities. One of these is to develop a Standard of Practice for Episodic, House Calls, and Walk-In Clinics Primary Care. The Terms of Reference for the Working Group were approved by Council in September 2021. The draft Standard was reviewed by Council in March 2022 and was distributed for consultation feedback with the registrants, public, and stakeholders. Much of this background was provided to Council at an earlier meeting, so it may look familiar.

Continuity of primary care is fundamentally important for the delivery of good medical care. Much of the medical system requires each person to have a family doctor to provide continuous medical care. Continuous medical care includes not only a longitudinal relationship between patient and physician, but also referrals to specialists, ordering of tests and follow-up, prescribing of long-term drugs, and at times, multiple attempts to treat medical conditions.

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

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

Some practice groups offer medical care on a same day walk-in or appointment with one physician in the practice group. That physician providing the episodic care will have access to the patient's

medical charts and will also be familiar with the style of the usual family doctor. In those cases, the usual family doctor may or may not be responsible for follow-up and referrals.

The traditional model of a doctor attending bedside in the patient's home to deliver medical care has almost disappeared. Some family physicians may still offer house calls for long-standing patients in their time of need. And physicians working in the WRHA Access Centres run a house call service for their patients unable to attend one of their physicians in the clinic. There are also limited house call services available in Winnipeg. While many patients use house calls because they are too ill to attend at a medical clinic, many resort to house calls because of mobility constraints – whether due to disability, socio-economic, or other. For instance, anecdotally, one of the higher users of house calls is the single mother of multiple children who can avoid taking the entire family on a bus for an appointment of one sick child.

Some have accused walk-in clinics of churning patients quickly for financial gain. Like any care provided, it depends upon the individual physician. To ensure good medical care in episodic, house calls, and walk-in clinics CPSM developed a Standard of Care for this type of care. Many other medical regulatory colleges in Canada have established rules to guide members in treating patients in episodic and walk-in clinics. There are no special rules for house calls, though some of that will fall under episodic care.

Themes from the Feedback of the Profession

The feedback was relatively robust from the profession and centred largely around four major themes:

- How necessary and valuable this type of care is for many who do not have family physicians, or whose family physicians do not treat patients beyond 9-5 M-F, or are vulnerable and socio-economically disadvantaged, or cannot travel to see a physician. Don't do anything to limit access to this care.

- Strong opposition to the absolute requirement to provide a copy of the medical record or summary of the clinical encounter to the primary care provider unless patient consent is not granted. Partnering with this theme is the corollary that the receiving physician would have to read all of the sent information. The criticism on both ends was that the administrative burden was high for very little benefit since much of the care was minor requiring no follow-up – including stitches, earwax removal, minor sprains, UTIs, etc.

- The Standard will require those providing episodic care to follow up on chronic disease management. In essence, the continuity of care and/or follow up care requirements mean that the walk-in doctor will be required to become the family doctor. This interpretation of the Standard was opposed.

- Specialized walk-in clinics such as sports medicine or Pan Am don't really fit this model and should be excluded.

- How does this type of episodic care fit in with chronic conditions and continuity of care.

A more detailed summary of the feedback was provided in the Summary of Feedback Themes."

In addition to the consultation feedback, subsequent to the Working Group making revisions, a group of physicians providing walk-in care had an evening discussion with the Registrar and General Counsel to provide explanations of how walk-in care is provided and certain provisions in the Standard. Input was also sought from Sports Medicine physicians and physicians practicing in the RAAM Clinics (Rapid Access to Addiction Medicine). All indicated they could comply with the Standard and very much appreciated CPSM reaching out to them.

Changes to the Standard Based Upon the Consultation Feedback

It is very helpful for those of us at CPSM to understand how this care is provided, especially when continuity of care is required for good medical care, though care may be fragmented in the health care system. It is so important to determine whether provisions in a Standard of Practice will disrupt or limit access to care and if so, how to address that prior to the implementation of a Standard of Practice. As always, trying to get the balance correct is a challenge and patient safety is paramount while recognizing system constraints. These changes seek to strike that balance and protect patient safety in the public interest.

All changes are tracked in the attached document. The major changes as summarized are the following:

1 – Sports Medicine Physicians Can Stick to Sports Medicine

The Standard now explains that sports medicine physicians only have to follow-up on sports medicine matters and should practice only within their scope of practice. This is also applicable to others who provide primary care in the community, but do not practice in a general family practice.

2 –Only Send Information to the primary care provider if, in your Clinical Judgment, it is Reasonable to Expect the Information will Help Ongoing Care

The Standard now requires the registrant to provide a copy or summary of the clinical encounter to the primary care provider if, in their clinical judgment, it is reasonable to expect the information will be useful for ongoing care of the patient. This replaces the absolute requirement to provide this information for every medical encounter.

3 – Not Required to Provide Long-term Chronic Care

For Chronic disease medical encounters, if the patient has a primary care provider, then the registrant is to provide the necessary short-term care then refer back to the primary care provider at earliest

possibility. If the patient does not have a primary care provider, then initiate treatment of the chronic disease and support the patient. The registrant is not required to take the patient into their family practice.

4 – Separate Rules for Chronic and Non-Chronic Diseases

This was an area of much feedback in the consultation and discussion by the Working Group and others. In the end, two separate rules were developed for chronic and non-chronic diseases. For chronic disease medical encounters, if the patient has a primary care provider, then short-term care is to be provided and the patient referred back to the primary care provider. If there is no primary care provider, they must initiate treatment of the chronic disease and support the patient but are not required to take on the patient into their family practice.

If it is not a chronic disease, then the registrant must generally assume responsibility for the medical care and provide follow-up to investigations, diagnosis, treatment, and test results.

5 – Create a Contextual Information and Resources Document

This provides elaboration with examples to assists registrants in addressing scenarios and issues with greater explanations. Generally, if people understand the rationale for a rule, then they will seek to comply. This document should answer a lot of questions and assist in successful adoption of this Standard. This document addresses many of the issues and scenarios raised in the consultation feedback.

Like any Standard, it is drafted with overall principles, and it cannot address every possible clinical encounter. Registrants will be required to use their clinical judgment and handle the matter in the best interest of the patient.

Documents

Attached are two versions of the Standard of Practice. The first is the final copy for which approval is sought. The second is the version blacklining the revisions to the version that was distributed for consultation. Also attached is the Contextual Information and Resources document which was prepared after the consultation.

PUBLIC INTEREST RATIONALE

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

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

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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

Standard of Practice

Episodic Visits, House Calls, and Walk-in Primary Care DRAFT

Initial Approval: **Effective Date:**

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

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

PREAMBLE

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

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

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

DEFINITIONS

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

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

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

Part 1. APPLICATION

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

1.2 This Standard does not apply to care provided in:

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

Part 2. STANDARD OF CARE

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

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

2.3. Registrants who limit the care or services they provide due to the episodic nature of their care must only do so in good faith[1].

2.4. Registrants must communicate any limitations of episodic care to patients in a clear and straightforward manner; and communicate appropriate next steps to patients, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care.[2]

[1] For example, a sports medicine physician may limit care to musculoskeletal conditions, or a family physician may limit pre-natal care if that is not within their scope of practice. However, no general family physician can refuse to treat patients in pain or with common chronic conditions.
[2] Special consideration should be taken for patients that might experience difficulties in such communication, including those with intellectual disabilities, limited English (or other same language), or patients with a mental illness that might limit effective communication.

Part 3. PRIMARY CARE PROVIDER

3.1. Patients must be asked if they have a primary care provider who they currently see for care and, if able to provide a name and clinic, both must be recorded on the patient's record.

3.2 The registrant must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider where:

- the patient consents and
- using clinical judgment, it is reasonable to expect the information in the copy or summary will be useful to the primary care provider for the ongoing care of the patient or if requested by the patient. [3]

Part 4. SUPPORTING PATIENTS

4.1. If primary care providers are present in the community, registrants must use their professional judgment to determine whether it would be appropriate to advise patients:

4.1.1. That there are differences between episodic care and care that is provided as part of a sustained primary care provider-patient relationship; and

4.1.2. About the benefits of seeing their primary care provider for care or encouraging them to seek one out, if they don't already have one.

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

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

5.1. A registrant must generally assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the Standard of Practice for Good Medical Care and subject to the care being within their scope of practice.

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

5.3. Notwithstanding the above 5.1 and 5.2, for chronic disease medical encounters:

5.3.1. if the patient has a family doctor/primary care provider, provide the necessary short-term care and refer them back to the family doctor at the earliest possibility.

5.3.2. if the patient does not have a family doctor/primary care provider, then initiate treatment of the chronic disease and support the patient in accordance with

[3] An exception exists for treating 2SLGBTQ+, birth control, or other sexual health matters that the patient may want to be private.

section 4.1, including advising the patient to seek a family care provider. The registrant is not required to take the patient on into their family practice.

Part 6. PRESCRIBING

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

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

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

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

Standard of Practice

Episodic Visits, House Calls, and Walk-in Primary Care DRAFT

Initial Approval: **Effective Date:**

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

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

PREAMBLE

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

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

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

DEFINITIONS

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

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

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

Part 1. APPLICATION

1.1 This Standard applies to primary medical care provided through episodic care, walk-in clinics, and house calls (including episodic care clinics such as ~~PanAm~~ sports medicine c~~C~~linics, m~~M~~inor i~~I~~njury c~~C~~linics, Public Health Clinics including for Sexually Transmitted Infections, Contraceptive Clinic etc.).

1.2 This Standard does not apply to care provided in:

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

Part 2. STANDARD OF CARE

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

~~2.1.~~2.2. Registrants must meet the standard of practice of the profession, which applies regardless of whether care is being provided in a sustained or episodic manner. For example, registrants practising in a walk-in clinic ~~and who provide episodic care~~ must conduct any assessments, tests, or investigations that are required for them to appropriately provide treatment. Registrants must also provide or arrange for appropriate follow-up care.

~~2.2.~~2.3. Registrants who limit the care or services they provide due to the episodic nature of their care must only do so in good faith[1].

~~2.3.~~2.4. Registrants must communicate any limitations of episodic care to patients in a clear and straightforward manner; and communicate appropriate next steps to patients ~~seeking care or services that are not provided~~, considering factors such as the urgency of the patient's needs and whether other health-care providers are involved in the patient's care.[2]

[1] For example, a sports medicine physician may limit care to musculoskeletal conditions, or a family physician may limit pre-natal care if that is not within their scope of practice. However, no general family physician can refuse to treat patients in pain or with common chronic conditions.
[2] Special consideration should be taken for patients that might experience difficulties in such communication, including those with intellectual disabilities, limited English (or other same language), or patients with a mental illness that might limit effective communication.

Part 3. PRIMARY CARE PROVIDER

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

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

3.2 The registrant must provide a copy or summary of the clinical encounter (including copies of ordered tests) to the primary care provider where:

- the patient consents and
- using clinical judgment, it is reasonable to expect the information in the copy or summary will be useful to the primary care provider for the ongoing care of the patient or if requested by the patient. [3]

Part 4. SUPPORTING PATIENTS

4.1. If primary care providers are present in the community, registrants must use their professional judgment to determine whether it would be appropriate to advise patients:

4.1.1. That there are differences between episodic care and care that is provided as part of a sustained primary care provider-patient relationship; and

4.1.2. About the benefits of seeing their primary care provider for care or encouraging them to seek one out, if they don't already have one.

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

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

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

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

[3] An exception exists for treating 2SLGBTQ+, birth control, or other sexual health matters that the patient may want to be private.

5.1. A registrant must generally assume responsibility for medical care and provide medical follow-up to investigations, diagnosis, treatment, and test results (whether critical or other) for that encounter in accordance with the provisions in the Standard of Practice for Good Medical Care and subject to the care being within their scope of practice.

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

5.3. Notwithstanding the above 5.1 and 5.2, for chronic disease medical encounters:

5.3.1. if the patient has a family doctor/primary care provider, provide the necessary short-term care and refer them back to the family doctor at the earliest possibility.

5.3.2. if the patient does not have a family doctor/primary care provider, then initiate treatment of the chronic disease and support the patient in accordance with section 4.1, including advising the patient to seek a family care provider. The registrant is not required to take the patient on into their family practice.

Part 6. PRESCRIBING

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

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

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

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

7.1.

Contextual Information and Resources

Episodic Visits, House Calls, and Walk-in Primary Care

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

FOLLOW UP CARE

If your patient requires follow-up for their medical condition, the expectation is to follow them for that one condition and only until addressed or stable or another primary care provider takes over. The expectation is not to take that patient on in your general family practice. The care must be within your scope of practice.

Typical clinical treatments that would not normally require follow up care includes generally healthy individuals with simple UTIs, flu/colds, minor traumas, contact dermatitis. Examples of more difficult cases that would generally require follow up care include instances where the diagnosis is unclear such as abdominal pain or fatigue; requests for refills of medications where the underlying chronic condition is poorly controlled; diagnosing and initiating pharmacologic treatment for anxiety and/or depression. Follow-up would also include where there are abnormalities found in diagnostics that flow from the episodic encounter, including incidental findings such as cardiomegaly or pulmonary nodule seen on a chest x-ray ordered to assess pneumonia.

The transfer back to the primary care physician does not require a formal referral. It may be an informal email, phone call, text.

PATIENT DOES NOT HAVE A FAMILY PHYSICIAN

Many patients do not have a family physician or other primary care provider such as a Nurse Practitioner. There is nothing in this Standard that requires you to become their family doctor. Similar to the follow-up care, you are to provide follow-up care for that particular medical condition and only until addressed or stable or another primary care provider assumes responsibility. This might mean a few visits to stabilize diabetes, it does not require longitudinal care for diabetes. Similarly, a prescription to treat COPD may not require further treatment of COPD where the patient is not experiencing a current exacerbation, though part of good medical care requires counselling the patient about the importance of smoking cessation in the management of their illness.

SPORTS MEDICINE

CPSM recognizes that sports medicine clinics are created to provide focussed primary and referral based musculoskeletal care by leveraging i) specialized infrastructure, ii) close working relationships with specialists including orthopedics and physical medicine, iii) expertise of primary care physicians with an additional competency.

Sports medicine doctors should limit their care to their scope of practice and what is in their knowledge, skill, and judgment. As one example, while blood pressure may be taken in the work up for low back pain, and the patient found to be moderately hypertensive, the sport medicine physician is not responsible for the treatment or further investigation and management of hypertension. Rather, the sports medicine physician should advise the patient to attend to their primary care provider or another general family doctor for further investigation and management. Sports medicine physicians may not be practicing outside of this defined scope and this Standard is not intended to have them practice within the wide-ranging scope of a family medicine practice.

RAAM CLINICS

Rapid Access to Addiction Medicine (RAAM) Clinics are specifically designed as easy access walk-in clinics for people seeking care related to substance use without an appointment or referral. RAAM clinics provide addiction medicine assessments and temporary substance use disorder care until patients can be connected to an appropriate long-term care provider, including their family physician or primary care provider. RAAM clinics do not provide general primary care, nor management of acute or chronic pain, or mental health concerns in the absence of addiction. The Standard does apply to the care provided in RAAM Clinics and the follow-up and continuity of care provisions only apply to addiction medicine.

HYBRID CLINICS or EPISODIC CARE WITHIN THE SAME CLINIC

Many clinics offer both general family practice and episodic care/walk-in care. This Standard applies only to the episodic/walk-in care provided in that clinic.

Many true group family practices permit walk-in appointments limited to the patients of that group practice. In that instance, follow-up care should be provided by the regular family doctor, but the transfer of care must still be accepted to ensure continuity of care. The notification must be more than a flag in an EMR – it can be a message through the EMR messaging system to accept care and follow-up.

NORTHERN REGIONAL HEALTH AUTHORITY

The NRHA has the unique advantage of having its own EMR connecting all NRHA run clinics and private clinics through an agreement so patient information is easily shared and accessed throughout the NRHA. Additionally, due to the geography, climate, and remoteness of many communities with no resident physician, a group shared practice may exist in some communities with rotating physicians. For registrants located and practicing in the NRHA CPSM recognizes the unique practice setting and patient demographics in the application of this Standard and the expansive definition of a group practice setting. As always, good medical care is required.

SEARCHING DPIN OR eCHART

The requirement for a DPIN or eChart search for other prescriptions is "as appropriate". This means using your clinical judgement and what is reasonable in the circumstances. Depending upon the medical condition of the patient, their co-morbidities, the patient's ability to recount their medical history, the drugs under consideration for prescription, and additional factors, good medical care may require a review of all other prescriptions. Any prescription for opioids and benzodiazepines requires a review of the DPIN or eChart in accordance with those Standards of Practice. There are many instances when there will be no need to review the prescribing history such as for antibiotics in an otherwise healthy patient.

For patients travelling into Manitoba, a call to their home pharmacy in another province or state may be required, depending upon the above factors.

CPSM recognizes that internet connectivity is not always possible, and you may wish to note that in the chart if this poses an issue.

LOCATING THE PRIMARY CARE PROVIDER

To assist in locating the primary care provider and address, eChart provides a primary care provider tab. Once logged into eChart, selected the "clinical Documents" header from the top portion of the screen. Next, click on the "+" sign to the left of "Primary Care Home Clinic" folder. This will allow you to see the name and practice location of the patient's primary care provider if they are currently enrolled with one in the province. Your office can search that to assist or prompt the patient if they are experiencing memory difficulties.

RESOURCES

CMPA "Walk-In Clinics: Unique Challenges to Quality of Care, Medical-Legal Risk"

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – SEPTEMBER 29, 2022

NOTICE OF MOTION FOR APPROVAL

TITLE: **Virtual Medicine - Standard of Practice**

BACKGROUND

CPSM was the first medical regulator in Canada to draft and implement a Standard of Practice for Virtual Medicine during the pandemic. Most of its Standard has become the framework for the national body, the Federation of Medical Regulatory Agencies of Canada, and is being adopted with some modifications across Canada. As many of you will recall, the Standard was introduced after the immediate widespread adoption of virtual medicine in March 2022 during the COVID-19 pandemic.

Much experience has been gained through the two years of virtual medicine and the 8 months since the Standard became effective. CPSM has been asked very frequently about various aspects of the Standard by many physicians and CPSM was approached by various department heads for further interpretation or a review of certain provisions in the Standard. While it is unusual to review a Standard after such little time, given the widespread nature of virtual medicine, the wide range of risks and benefits of virtual medicine and the varying uses of virtual medicine, it was decided to re-convene the Working Group along with several Department Heads and CMOs to review the Standard of Practice and its accompanying documents.

There were two virtual meetings. Concerns with the Standard were heard. Explanations were provided by CPSM staff, discussions were held, and alternate wording/further commentary provided in the Standard and supporting documents. The Working Group with the Department Heads/CMOs have all approved the recommended revisions to the Standard and documents.

At the outset, it should be noted that <u>there are no major changes to the Standard</u>. The General Provision has not been altered in any way:

> Each registrant's practice of medicine **must include timely in-person care** when clinically indicated or requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine. **A blended care model balancing in-person and virtual medicine is required if providing virtual medicine**.

Summary of Revisions

1 – General Principles

Concerns were expressed by those following the strict letter of the Standard and then trying to apply it to the myriad of circumstances. A use your clinical judgement provision to these general principles was added to the General Provisions:

> *The Standard has general principles which must be applied reasonably to every patient encounter using registrant's knowledge, skill, and judgment to determine if virtual medicine for that patient encounter is appropriate and in the best interest of the patient.*

2 – Assess the Appropriateness and Patient's Best Interest for Virtual Medicine

The original Standard had the requirement for the registrant to assess the appropriateness of using virtual medicine for each patient encounter. Added to this now is the patient's best interest. This is taken from the CPSO Standard which expands upon the CPSM Standard. This is seen as a positive inclusion and places the focus more squarely on what is best of the patient's care – and not the convenience of the CPSM registrant.

> *5.1.1 Use professional judgment to determine if virtual medicine is **appropriate and in the patient's best interest**. This means only providing virtual care when*
>
> *5.1.1.i The quality of the care will not be compromised; or*
>
> *5.1.1.ii The potential benefits of providing virtual care outweigh the risks to the patient.*
>
> *5.1.2 When determining whether virtual medicine is appropriate and in the patient's best interest the following must be considered:*
>
> *5.1.2.i The nature of the presenting condition and care required, including whether a physical examination is required to meet the standard of care*
>
> *5.1.2.ii The patient's existing health status and specific health-care needs;*
>
> *5.1.2.iii The patient's specific circumstances and preferences (eg. financial hardship, mobility limitations, distance required to travel to an in-person appointment, language/communication barriers);*

This was further elaborated upon in the Contextual Information and Resources:

> *The Standard only specifies a few circumstances where virtual care is or is not appropriate. Each patient's needs are unique, technology is evolving, and a number of the patient's considerations – clinical, geographic, demographic, mobility – will play into the type of care that is appropriate in each patient encounter. The Standard requires registrants to exercise the professional judgment to make these determinations on a case-by-case basis.*
>
> *A blanket virtual-first approach (ie triaging every patient with an initial virtual appointment) is to be avoided in the absence of direction from government (e.g. in relation to*

pandemics/public health measures). Use of a blanket virtual-first approach can delay necessary care and negatively impact patient safety as well as the system as a whole. Certain medical conditions and patients will require in-person care and consideration needs to be given to the purpose and nature of the appointment at the point of scheduling or triaging.

3 – Video

The requirement to use video for virtual medicine was softened to be based upon the nature of the clinical encounter. Many physicians spoke to their patient's reliance on the telephone and the reluctance to use video. However, this requirement to use video is based upon the actual nature of the clinical encounter and whether the standard of care can be fulfilled without video. Exemptions remain for poor internet, lack of internet savvy, etc.

4 – Mental Health and Psychiatry

CPSM was provided with studies from psychiatry indicating that there was little to no clinical difference between care provided virtually or in person. Accordingly, the Contextual Information was altered to indicate that most psychiatry and mental health encounters can be safely provided through virtual medicine with the occasional in person session.

The Standard mandates the use of video technology depending upon the nature of the clinical encounter, if available, if in the best interest of the patient, and if preferred by the patient.

Virtual appointments can be conducted either by video or by phone. Many surveyed patients express a preference for a video appointment, and such appointments clearly provide non-verbal cues and a degree of physical assessment that cannot be duplicated with a voice-only form of communication. Accepting this premise, there are also obvious advantages to phone appointments, including the need for less sophisticated technology, the ability for patients to be less constrained in where the "appointment" takes place, and greater ease of integrating the virtual appointments into an outpatient clinic setting that also includes in-person visits.

To best meet the expressed needs and desires of patients, virtual appointments should be scheduled as video appointments when technically feasible, if the patient desires it, and if required for good medical care. Phone appointments may be substituted if acceptable to the patient, and in particular when the patient is well known to the care provider and where visual cues are unlikely to yield additional information.

It is imperative that virtual appointments of any sort be conducted in such a fashion that a patient can be reviewed in-person at short notice as needed or requested. It is also important

to reiterate that in most instances virtual appointments should be intermingled with and complement in-person appointments, so valuable close-proximity cues are not missed.

5 – Physician Wellness

Virtual medicine can be a both a benefit and a negative for physician's wellness.

Virtual medicine can assist your wellness and prevent burn-out by permitting the continuation of treating patients virtually. However, physicians should be cautioned in using virtual medicine while they themselves are sick. Instead, use the time to recuperate and recharge. Virtual medicine can make the physician "always available". Set parameters for work and non-work.

6 – Ratio of Virtual to In-Person Care

CPSM heard requests from many seeking direction from CPSM as to what percentage of a medical practice could be conducted virtually. There is no percentage of visits required to be taken in-person.

This ratio will vary by specialty and even within specialty, and even by patient, and even for that patient's particular needs. For instance, a CancerCare surgical oncologist will have to physically touch and assess lymph nodes prior to scheduling an operation, but a CancerCare medical oncologist may be able to monitor the patient by reviewing PSA levels and virtual visits. For psychiatry, psychiatric care for high-risk populations will require more in-person care than a lower risk patient population, however a suicidal patient may be treated immediately on the telephone for patient safety. For family medicine general practice, depending upon your patient population's geographic-socio-economic-health-age demographics, and individual medical conditions that percentage will change too.

7 – Providing Care to Patients in Manitoba

CPSM has heard many requests from physicians to treat their patients virtually as they travel the globe. It was thought important to explain why this should not be done.

Why is it important to confirm that the patient is in Manitoba?
Five reasons.

1. *You may not be able to order tests, prescribe drugs, refer to a specialist, or undertake a timely in-person assessment if required. This does not constitute good medical care.*
2. *Depending upon where that patient is located, you may be considered by that location to be practicing medicine in that jurisdiction and will need to be licensed there. The rules are*

different for every jurisdiction, both within Canada, amongst the 50 different US states, and in other countries worldwide.

3. *You may not have CMPA coverage. "The CMPA is structured to assist members who encounter medical-legal difficulties arising in Canada from their medical professional work done in Canada. The CMPA does not generally assist with difficulties that arise outside of Canada or that result from care provided outside of Canada, owing to the potential for prohibitively expensive legal actions in other jurisdictions, particularly the United States."*
   https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/practising-telehealth
4. *CPSM is informed by Doctors Manitoba that the virtual care tariff is only to be charged for patients located in Manitoba, NorthWestern Ontario, and Nunavut.*
5. *Health care is provincial, not federal, and it is governed by Manitoba legislation. Different legislation exists in other provinces and countries and governs the practice of medicine there.*

8 – Virtual On-Line Platforms

Both the Working Group and Council were clear in the original Standard that using the virtual online platforms delivery of virtual medicine in which patients contact random physicians did not meet the standard of good medical care.

This has been re-iterated, however with this proviso that the physician themselves must be able to provide in-person care to that patient in a timely manner:

> Digital platforms in which patients contact physicians virtually, on-demand do not conform to the requirements of the Standard *unless that individual physician themselves can provide in-person care within 24-48 hours in a geographic location close to the patient's location. This might be in the same city, or if rural/remote within the usual distance for rural/remote health care.*

If a virtual on-line platform can provide in-person care by the same physician, then that is permitted since if there is appropriate in-person care then that could constitute good medical care.

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

These amendments embody recognition that the virtual medicine Standard must be updated to ensure the delivery of virtual medicine is in the best interest of the patient, and that the delivery of

good medical care continues – whether in-person or virtually. Virtual medicine has been embraced by both patients and medical profession, yet for both patients and physicians it may be lacking at times. These revisions, particularly those regarding the patient's best interest, ensures the delivery of virtual medicine be in the best interest of the patient's health – and not necessarily their convenience or their preference.

The balance of providing virtual medicine compared to in person medicine must always be in the best interest of the patient for that particular medical condition in that appointment. These revisions re-iterate and expand upon the rationale and clinical judgment to be used to determine if virtual medicine is the appropriate standard of care for each encounter.

Documents

Attached are the revised blacklined versions of the Standard of Practice, Contextual Information and Resources, and the FAQs. Council is only asked to approve the Standard of Practice. The other two documents are provided for information only and as further explanations of the revisions.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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

Standard of Practice

Virtual Medicine

Initial Approval: September 29, 2021 **Effective Date: November 1, 2021**

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

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

1. DEFINITION AND APPLICATION

1.1. Virtual Medicine means the provision of medical care by means of electronic communication (telephone, video, email, text, or other internet hosted service or app) where the patient and the registrant are at different locations, including but not limited to treating, advising, interviewing or examining the patient. *CPSM Standards of Practice Regulation*, s. 1.

1.2. This Standard does not apply to medical consultations or communications between CPSM registrants, nor to communications between CPSM registrants and other regulated health professionals.

2. ETHICAL, PROFESSIONAL, AND LEGAL OBLIGATIONS

2.1. Providing care by virtual medicine does not alter the ethical, professional, and legal obligations of registrants to provide good medical care.

2.2. CPSM recognizes the importance of virtual medicine in providing care and access to care, especially for patients in remote and underserviced areas, patients with disabilities, patients in institutional settings, limited psychosocial supports or economic means, and in a pandemic, or state of emergency.

2.3. **Virtual medicine is to be used to optimize and complement in-person patient care**.

2.4. The role of CPSM is to regulate registrants and their use of technology, not technology itself.

2.5. Registrants must provide virtual medicine in accordance with this Standard of Practice.

3. GENERAL PROVISIONS

3.1. Each registrant's practice of medicine **must include timely in-person care** when clinically indicated or requested by the patient. It is not an acceptable standard of care to solely practice virtual medicine. [1] **A blended care model balancing in-person and virtual medicine is required if providing virtual medicine**.

3.2. The Standard has general principles which must be applied reasonably to every patient encounter using registrant's knowledge, skill, and judgment to determine if virtual medicine for that patient encounter is appropriate and in the best interest of the patient.

4. PRIOR TO ENGAGING IN VIRTUAL MEDICINE

4.1. Licensure

4.1.1. Physicians providing virtual medicine to Manitoba patients located in Manitoba must be registered with CPSM.

4.1.2. Registrants must be aware of and comply with the licensing requirements in the Canadian jurisdiction in which the patient is located. Many jurisdictions require physicians to hold a license and have liability protection to treat a patient located in that jurisdiction.

4.1.3. If providing care across the Manitoba border, physicians must be familiar and comply with the legalities of licensure as outlined in the Contextual Information and Resources and Across Borders documents following this Standard.

4.2. Establishing the Patient-Physician Relationship

4.2.1. Registrants using virtual medicine to provide medical care to patients must:

4.2.1.i. Disclose their identity to the patient and confirm confidentiality of the encounter;

4.2.1.ii. Take reasonable steps to confirm the patient's identity and that the patient is located in Manitoba;[2]

4.2.1.iii. Ask the patient if the physical setting is appropriate given the context of the encounter and ensure consent to proceed;

4.2.1.iv. Offer the patient the opportunity for in-person care.

5. DURING AND AFTER ENGAGING IN VIRTUAL MEDICINE

5.1. Assess the Appropriateness and Patient's Best Interest of Using Virtual Medicine for Each Patient Encounter. Registrants must:

[1] Registrants providing virtual medicine exclusively in remote communities may do so if part of the institutional health care system.

[2] See the attached document, Information Sheet on Virtual Medicine Across Provincial and International Borders and relevant question in FAQs attached to this Standard.

~~Assess the patient's presenting condition and the appropriateness of virtual medicine to provide care; if not appropriate, then must recommend and offer an in-person assessment~~;

5.1.1 Use professional judgment to determine if virtual medicine is **appropriate and in the patient's best interest**. This means only providing virtual care when

5.1.1.i The quality of the care will not be compromised; or

5.1.1.ii The potential benefits of providing virtual care outweigh the risks to the patient.

5.1.2 When determining whether virtual medicine is appropriate and in the patient's best interest the following must be considered:

5.1.2.i The nature of the presenting condition and care required, including whether a physical examination is required to meet the standard of care

5.1.2.ii The patient's existing health status and specific health-care needs;

5.1.2.iii The patient's specific circumstances and preferences (eg. financial hardship, mobility limitations, distance required to travel to an in-person appointment, language/communication barriers);

.

5.1.3 Ensure they have sufficient knowledge, skill, judgment, and competency (including technological) to manage patient care through virtual medicine;

5.1.4 Ensure they have satisfactory technology to provide virtual medicine;

5.1.5 Based upon the nature of the clinical encounter use video technology if available, if in the best interest of the patient, and if preferred by the patient.

5.2. Provide Good Medical Care

5.2.1. Registrants providing virtual medical care must:

5.2.1.i. Provide all elements of good medical care as required. *CPSM Standard of Practice Regulation*, s. 3

5.2.1.ii. **Have the ability themselves[3] to provide a timely physical assessment of the patient.** A limited exemption applies for patients in distant rural, remote, or institutional locations if this will hinder access to care.[4] Directing patients to another healthcare facility, a walk-in clinic, or the Urgent Care or Emergency Department in non-urgent or non-emergent circumstances in lieu of an in-person assessment is not appropriate care;

5.2.1.iii. Ensure continuity of care and have the same obligations for patient follow-up as in in-person care;

5.2.1.iv. Ensure patients referred to specialists are appropriately investigated and treated before referral. If an assessment of the patient's presentation requires a physical before referral, the referring registrant must ensure that one is done. It is unacceptable to defer

[3] In a true group shared primary care practice in a physical clinic with shared medical records, then the timely physical assessment of your own patient whom you usually see in person, may be performed by another member of that group practice.

[4] Specialists have a greater latitude in providing timely care, usually due to health care system waits or the difficulties for many patients to travel distances.

such a physical assessment to the specialist unless agreed to in advance. An exemption applies for patients in distant rural, remote, or institutional locations if this will hinder access to care;

5.2.1.v. Pay additional attention to ensuring the patient understands the information exchanged and is not hindered by the technology;

5.2.1.vi. Adapt the technology for virtual medicine for patients who are deaf, hard of hearing, or visually impaired.

5.2.2 Registrants providing care for Ongomiizwin Health Services and Northern Manitoba, CancerCare Manitoba, or other public organizations supporting medical care including hospitals or long-term care facilities, may rely upon institutional supports and systems for the delivery of virtual medicine.[5]

5.3. Patient Records, Privacy, Confidentiality, Security of, and Access

5.3.1. Registrants providing virtual medicine must create and maintain patient records the same as in in-person care and adhere to that Standard of Practice.

5.3.2. Registrants should usually have active access to the patient's medical record while providing virtual medicine.

5.3.3. Registrants must carefully consider the appropriateness of obtaining photo or video from patients by electronic means and ensure the consent, lawful viewing, and confidential storage of such patient records.

6. PRESCRIBING AND AUTHORIZING

6.1. Registrants using virtual medicine must:

6.1.1. Conduct an assessment in accordance with the standard of care before prescribing or authorizing a drug, substance, or device, and only proceed to do so if appropriate;

6.1.2. Exercise caution when providing prescriptions or other treatment recommendations to patients they have not personally examined;

6.1.3. Not prescribe opioids or benzodiazepines or Z-Drugs or authorize cannabis for medical purposes to patients whom they have not examined in person, or with whom they do not have a longitudinal treating relationship, unless they are in direct communication with another regulated healthcare professional who has examined the patient.

[5] For instance, if safe to the patient, a physician providing care to a remote community may rely upon a nurse practitioner in the community to perform a physical assessment, or a specialist may rely upon a family doctor in a rural area to perform a physical assessment. These institutions might also have special alternate arrangements for delivery of care to distant rural and remote patients.

Contextual Information and Resources

Virtual Medicine

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

Importance of Physical Assessments to meet the Standard of Care

The art and science of medicine usually requires in-person care to create trust with the patient, demonstrate empathy, support patients, correctly assess the medical condition, and enhance the connection between patient and physician. In-person encouters are often critical for the non-verbal element of communication between patient and physician.

Many physicians adapted to virtual medicine immediately in March 2020 due to the COVID-19 pandemic, and Manitoba was in a state of lock-down restrictions. This permitted virtual medicine to treat medical conditions that otherwise would have required in-person care.

CPSM encourages its registrants to provide in-person medical care in ~~for most of~~ **their practice because the physical assessment of patients is critical to good medical care and the patient-doctor relationship**. Prescription refills or some chronic care for long-standing patients may not require a physical assessment, nor would delivery of ~~the most favourable~~ test results.

Virtual Medicine – Appropriate and Patient's Best Interest

The Standard only specifies a few circumstances where virtual care is or is not appropriate. Each patient's needs are unique, technology is evolving, and a number of the patient's considerations – clinical, geographic, demographic, mobility – will play into the type of care that is appropriate in each patient encounter. The Standard requires registrants to exercise their professional judgment to make these determinations on a case-by-case basis in the patient's best interest.

A blanket virtual-first approach (ie triaging every patient with an initial virtual appointment) is to be avoided in the absence of direction from government (e.g. in relation to pandemics/public health measures). Use of a blanket virtual-first approach can delay necessary care and negatively impact patient safety as well as the system as a whole. Certain medical conditions and patients will require in-person care and consideration needs to be given to the purpose and nature of the appointment at the point of scheduling or triaging.

Virtual Medicine Not Meeting the Standard of Care

The requirement is to provide timely in-person medical care. Examples of virtual medicine that do not meet the Standard are:

- Virtual medicine-based businesses that do not offer timely in-person appointments by the same physician (within 24-48 hours)
- Physicians not offering in-person appointments, including during a pandemic, unless advised by a health authority to not see patients in person
- Physicians ~~unnecessarily~~ restricting in-person visits with patients or limiting in-person appointments inappropriately or without objective rationale.

Good medical care ~~usually~~ requires the ability for timely in-person assessments ~~unless for refills or chronic care for long-standing patients~~. The following are examples of likely failing to provide good medical care through virtual medicine:

- Complete physicals
- Assessments for return to work unless mental health
- Any concern that requires direct hands-on examinations, i.e., abdominal examination
- Any concern that requires a direct visual observation
- Independent Medical Examinations that require physical assessment

Referrals to a Specialist Without a Physical Examination

~~Numerous specialists have advised that they have been referred patients who have not been seen in-person for medical care that could have been provided by a family physician in-person.n. For instance, an ENT has received many referrals for earaches, but the family doctors have not performed an in-person examination which would have detected a condition that the family doctor could address.~~

The general rule for good medical care is to perform a physical examination prior to referral to a specialist. There are, however, examples of referrals that can be made to specialists without having first seen the patient. These include:

- Obvious significant or urgent medical conditions
- Referral of long-term substance use disorder to addictions medicine
- Referrals of distant rural and remote patients if the in-person assessment will hinder or unduly delay care

Mental Health and Psychiatry

Most psychiatry and mental health encounters can be safely provided through virtual medicine with the occasional in-person session. Again, use your knowledge, skill, and judgment to determine if your patient requires in-person care for their mental health care.

While the counseling for mental health matters might seem best suited for virtual medicine, CPSM will caution that many aspects of mental health care require in-person care to be competent care. A physical assessment might be required to assess the patient's appearance, actions, mannerisms, countenance, etc. This may or may not be achieved by video, and video is highly encouraged by CPSM for all virtual encounters in mental health. ~~Similarly, the creation of a successful patient-physician relationship is more likely in person than through virtual medicine.~~

An exemption may exist for treating those patients in rural and remote areas or living in institutions (personal care homes, group homes, hospitals, correctional centres, etc.) where in-person access may be difficult.

Psychiatric independent medical examinations may be conducted virtually in most instances.

Video Preferred Option

~~A CPSM survey of patients indicated that 98% of virtual medicine patient encounters were undertaken by telephone. Patients in the same survey indicated their strong preference for video clinical encounters, not telephone. The Standard mandates the use of video technology depending upon the nature of the clincal encounter if available, if in the best interest of the patient, and if preferred by the patient. Video is the preferred option. However, if a video option is unavailable or refused by the patient, default to a telephone may suffice if deemed safe for the patient.~~

The Standard mandates the use of video technology depending upon the nature of the clinical encounter, if available, if in the best interest of the patient, and if preferred by the patient.

Virtual appointments can be conducted either by video or by phone. Many surveyed patients express a preference for a video appointment, and such appointments clearly provide non-verbal cues and a degree of physical assessment that cannot be duplicated with a voice-only form of communication. Accepting this premise, there are also obvious advantages to phone appointments, including the need for less sophisticated technology, the ability for patients to be less constrained in where the "appointment" takes place, and greater ease of integrating the virtual appointments into an outpatient clinic setting that also includes in-person visits.

To best meet the expressed needs and desires of patients, virtual appointments should be scheduled as video appointments when technically feasible, if the patient desires it, and if required for good medical care. Phone appointments may be substituted if acceptable to the patient, and in particular when the patient is well known to the care provider and where visual cues are unlikely to yield additional information.

It is imperative that virtual appointments of any sort be conducted in such a fashion that a patient can be reviewed in-person at short notice as needed or requested. It is also important

to reiterate that in most instances virtual appointments should be intermingled with and complement in-person appointments, so valuable close-proximity cues are not missed.

Considering Patient Preferences Regarding Virtual Medicine

Considering and negotiating patient preferences is not merely an information exchange but an opportunity to initiate a dialogue between physician and patient in which both attempt to arrive at a mutually satisfactory course of action. When deciding between virtual vs. in-person visits or video vs. telephone options, the physician may use the following framework:

Elicit Preferences

What are the patient's circumstances (convenience, mobility, financial, location, social, and communication limitations)?

Determine Goals

What are the goals of this visit? For the patient? For the physician?

What are the benefits and detriments of virtual vs. in-person visit or video vs. telephone visit for that particular patient encounter?

Virtual Care for Distant Rural and Remote

CPSM recognizes the importance of virtual medicine for many patients living in distant rural and remote areas, especially those residing in First Nations. Virtual medicine has enabled these patients to access health care with greater ease which is supported by CPSM. Physicians treating patients living in these areas are encouraged to continue using virtual medicine, so long as it is safe for the patient and provides good medical care. The Standard will be interpreted in the context of that care for patients.

For instance, CancerCare may continue to do virtual medicine without seeing these patients if safe to do so. The same for obstetricians and pediatricians conducting medical care in the North through institutional supports – which may include having a nurse practitioner in the community perform the physical assessment, or a urologist in Winnipeg may utilize photos or videos to assess and treat remote patients that would otherwise require lengthy travel to an urban centre for a quick assessment. These are just a few examples of virtual medicine that could be utilized for distant rural or remote patients.

Virtual Care for Opioid Agonist Treatment

For Opioid Agonist Treatment, CPSM recognizes the importance of virtual medicine providing immediate medical care in situations where in-person care might not otherwise be possible.

Access to continuous good medical care (whether virtual or in-person) is in the best interest of this unique patient group receiving opioid agonist treatment. Flexibility in the Standard is permitted for appropriate medical care when in the best interest of the patient using your knowledge, skill, and judgment for this high risk patient group.

Virtual Medicine and Physician Wellness

Virtual medicine can assist your wellness and prevent burn-out by permitting the continuation of treating patients virtually. However, physicians should be cautioned in using virtual medicine while they themselves are sick. Instead, use the time to recuperate and recharge. Virtual medicine can make the physician "always available". Set parameters for work and non-work.

Across Provincial and International Borders

See INFORMATION SHEET ON VIRTUAL MEDICINE ACROSS PROVINCIAL AND INTERNATIONAL BORDERS

Suggested Resources

- Virtual Care Playbook by CMA/CFPC/RCPSC. This playbook was written to help Canadian physicians introduce virtual patient encounters into their daily practices. https://www.cma.ca/virtual-care-playbook-canadian-physicians

- Virtual Care in the Patient's Medical Home by CFPC. The Patient's Medical Home is the model of family medicine for Canada supported by the CFPC. https://www.cma.ca/virtual-care-playbook-canadian-physicians

- Virtual Care Guide for Patients by CMA/CFPC/RCPSC. This has been prepared to help patients prepare for virtual visits with their physician. https://www.cma.ca/sites/default/files/pdf/Patient-Virtual-Care-Guide-E.pdf

- See Doctors Manitoba for Resources and Tariffs https://doctorsmanitoba.ca/managing-your-practice/covid-19/virtual-care

  https://doctorsmanitoba.ca/managing-your-practice/covid-19/virtual-care/virtual-care-across-borders

- CMPA Protecting Patient Privacy When Delivering Care Virtually

Virtual Medicine Standard of Practice FAQ

The Standard of Practice for Virtual Medicine has general principles which must be applied reasonably to each and every patient encounter and should be documented. The new Standard of Practice for Virtual Medicine has led to many questions. Here are several of the questions and answers provided.

I sometimes pick up calls for a virtual online platform. Can I continue to do so with the new Standard?

Generally no, unless you yourself can provide in-person care to that patient. Fundamentally, *virtual medicine is to be used to optimize and complement in-person patient care – it is not a substitute for in-person care.* This means that the physician-patient relationship is to be in-person and virtual medicine is to be used to enhance in-person care. There is a requirement for a blended model of care requiring each registrant to see their patient in person in a timely manner if needed. Digital platforms in which patients contact physicians virtually, on-demand do not conform to the requirements of the Standard unless that individual physician themselves can provide in-person care within 24-48 hours in a geographic location close to the patient's location. This might be in the same city, or if rural/remote within the usual distance for rural/remote health care.

I am a psychiatrist. Does this Standard apply to psychotherapy?

Yes, it applies to all patient encounters. Anyone performing psychotherapy must have a blended model of care with both in-person and virtual visits. Virtual medicine is to be complementary to in-person care, not a substitute for in-person care.

The recent Standard of Practice on virtual medicine requires each physician to provide a blended model of in-person and virtual appointments depending upon the patient's clinical needs, amongst other considerations. For a psychiatrist, the CPSM expectation is that many patients can have a blended model in which the psychiatrist delivers much of their care virtually ~~but every few visits should be an in-person appointment~~. Depending upon the patient's medical condition, the psychiatrist has the discretion to determine the frequency of the in-person encounters, unless the patient requests an in-person appointment and then a timely in-person assessment is

required. The frequency of in-person appointments will vary widely on the patient's needs, but an in-person clinical encounter is required periodically.

Many of my patients are elderly and have difficulties in travelling and want virtual visits. How can I comply with the Standard of Practice?

CPSM recognizes the importance of virtual medicine in providing care and access to care, especially for patients in remote and underserviced areas, patients with disabilities, patients in institutional settings, limited psychosocial supports or economic means, and during a pandemic, or state of emergency. This may include the elderly.

Depending upon your individual patients, a blended model balancing in-person and virtual medicine may require the patient to attend in person once every two or three visits. Other patients will require all visits to be in person. All of this depends upon your clinical judgment for each and every patient encounter and should be documented in the patient record. Your clinical judgment will also take into account that your patient may not be able to drive or have family that can bring them to an in-person appointment. Therefore, a virtual visit may be the only way the patient can access health care. Most importantly, if good care requires in-person care, then in-person care must be provided.

Some of my elderly patients only use telephones (not smartphones) for virtual medicine. Can I meet the Standard of Practice by only using a voice?

The Standard states to use video technology if available, if in the patient's best interest, and if preferred by the patient. It was specifically written to ensure access to care for patients such as the elderly who may not have a computer or video access and only use the traditional telephone. However, you will recognize the importance of non-verbal communication that cannot be captured by phone and so the phone can be limiting in some instances. Most visits are strongly encouraged to be in-person unless for routine filling of prescriptions or advising of non-problematic test results or as in the above question.

Is there a percentage of visits that are required for in-person vs virtual visits?

No. This ratio will vary by specialty and even within specialty, and even by patient, and even for that patient's particular needs. For instance, a CancerCare surgical oncologist will have to physically touch and assess lymph nodes prior to scheduling an operation, but a CancerCare medical oncologist may be able to monitor the patient by reviewing PSA levels and virtual visits. For psychiatry, psychiatric care for high-risk populations will require more in-person care than a

lower risk patient population, however a suicidal patient may be treated immediately on the telephone for patient safety. For family medicine general practice, depending upon your patient population's socio-economic-health-age demographics, and individual medical conditions that percentage will change too.

I have to provide family support for my elderly parent in Ontario for a week. Can I do some virtual visits with my Manitoba patients while I am in Ontario?

Yes. The recent Standard of Practice on Virtual Medicine requires timely in-person care when clinically indicated or requested by the patient. If there is a requirement for an in-person assessment, please arrange for a colleague to see your patients that require in-person care.

I am travelling outside of Canada. Can I do some virtual visits with my Manitoba patients while I am outside Canada?

No. There are privacy considerations and possible legal impediments to your patients' personal health information being accessed anywhere outside of Canada (including the United States). The requirements of the Standard of Practice and providing good medical care cannot be met if there are privacy and legal impediments to accessing and creating your patients' medical records outside Canada. Furthermore, many jurisdictions will consider you to be practicing medicine – without a licence!

I am registered in another province. Can I conduct virtual medicine visits for Manitoba patients?

No. The patient's location in Manitoba means that you are practicing medicine in Manitoba without a licence. There are a few limited exemptions for federal jurisdictions such as federal prisons, military, airline transportation. There are also exemptions for complex care that is organized through Shared Health such as transplant surgeries and follow-up care and pediatric cardiac surgeries through Children's Hospital.

My patient moved out of the province. Can I continue to provide care through virtual medicine?

No. The Standard requires a blended model of in-person and virtual visits in a timely manner, so this will not be possible. Furthermore, if the patient has moved, they are a resident of another province and must seek healthcare within that province. The patient is to have a local prescriber, and should they require the care of a specialist or scheduled procedures, these are to be

performed in their home province. Note – Patients living in Northwestern Ontario may be treated via virtual medicine for acute care follow-up or cancer care. However, depending upon the nature of the care being provided you may continue to treat your patient while they establish residency in another province (for instance the 90-days while they obtain another health card) if you have a license to practice medicine in that province or that province allows virtual medicine based upon your Manitoba registration.

Why is it important to confirm that the patient is in Manitoba?

Five reasons. 1 - You may not be able to order tests, prescribe drugs, refer to a specialist, or undertake a timely in-person assessment if required. This does not constitute good medical care.

2 - Depending upon where that patient is located, you may be considered by that location to be practicing medicine in that jurisdiction and will need to be licensed there. The rules are different for every jurisdiction, both within Canada, amongst the 50 different US states, and in other countries worldwide.

3 - You may not have CMPA coverage. "The CMPA is structured to assist members who encounter medical-legal difficulties arising in Canada from their medical professional work done in Canada. The CMPA does not generally assist with difficulties that arise outside of Canada or that result from care provided outside of Canada, owing to the potential for prohibitively expensive legal actions in other jurisdictions, particularly the United States." https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/practising-telehealth

4 - CPSM is informed by Doctors Manitoba that the virtual care tariff is only to be charged for patients located in Manitoba, NorthWestern Ontario, and Nunavut.

5 – Health care is provincial, not federal, and it is governed by Manitoba legislation. Different legislation exists in other provinces and countries and governs the practice of medicine there.

My patients are snowbirds. Can I provide virtual medicine visits while they are south?

No. See above. ~~That may be considered practicing medicine in that state or country without a licence. Your CPSM registration is for practicing medicine on patients located in Manitoba. Furthermore, CPSM is advised by Doctors Manitoba that billings cannot be submitted for such patients.~~

There is a snowstorm warning. Can I close my clinic and offer virtual medicine to those scheduled patients?

Yes overall, depending upon your practice. This is a benefit of virtual medicine both for the patients and registrants. However, some of those patients will likely have to be seen in-person, and some immediately after the storm. Similarly, if a physician can not travel in the North or rural areas due to weather or airplane delays then virtual medicine may used to provide care if appropriate. Again, some of those patients may require in-person care soon.

I want to provide virtual medicine only. Can I have an arrangement with a physical clinic to refer patients who require in-person care?

No. You yourself have to provide timely in-person care and this care has to be in reasonable geographic proximity to the patients.

Can I move to another province, continue to be registered with CPSM, and just see my Manitoba patients virtually?

No. Again, you yourself must provide timely in-person care and this care has to be in reasonable geographic proximity to the patients. That timely in-person care might be required within 24-48 hours.

I am a specialist scheduled to provide in-person consultation services. Can I perform the initial assessment to interview the patient virtually and subsequently perform the in-person assessment?

Yes, for the most part. For instance, as a neurologist travelling to a distant rural or remote area to treat a number of neurology patients, you can interview your patients virtually first and then perform the in-person assessment later as scheduled when you travel to treat them. This applies whether you are a specialist living in Winnipeg or another province and travelling to the distant rural or remote area.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – SEPTEMBER 29, 2022

NOTICE OF MOTION

TITLE: **Truth and Reconciliation Commission: Addressing Indigenous-Specific Racism in Medical Practice**

BACKGROUND

Council has chosen TRC: Addressing Indigenous-Specific Racism in Medical Practice to be a Strategic Organizational Priority.

Attached are the Terms of Reference for the TRC Advisory Circle. Although it is not the usual practice to include the Terms of Reference for a Working Group, this priority is rather unique compared to the more usual and raises unique and sensitive governance issues.

The TRC Advisory Circle has met on seven occasions and has seven initial recommendations for Council. These initial recommendations for Council are the following:

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

See attached for a list of the members of the Advisory Circle chosen by Dr. Monkman, based upon their backgrounds, medical practices, expertise, and experiences.

RECOMMENDATIONS

Each recommendation has an explanation written by CPSM staff to ensure Council better understands the context and content of the recommendation. The elaboration below merely reflects comments made by members of the TRC Advisory Circle and notations by CPSM staff. Each of these recommendations will be developed in due course, should Council approval be granted.

CPSM staff are grateful to all those participating in the TRC Advisory Circle and imparting their knowledge, experiences, and advice for the benefit of CPSM. It is recognized that the matters discussed have been difficult and personal to every individual on the TRC Advisory Circle.

1 – Apology and Statement by CPSM on Indigenous-Specific Racism

- Acknowledge that Indigenous racism exists in medical practice and regulation
- Site specific failures of the medical profession (forced sterilization, starvation experimentation, segregated hospitals, residential schools, stereotyping in care, poor medical care, poor health outcomes, etc)
- Commit to eradicating Indigenous racism in CPSM work and the work of the medical professionals it regulates
- Support allies to address and eradicate Indigenous racism in the practice of medicine
- Recognize right of Indigenous persons to traditional Indigenous health care
- Develop relationships with Indigenous partners for change
- Recognize racism as professional misconduct and regulate or hold to account those who breach the expected conduct.
- Commit to change.

2 - CPSM Land Acknowledgment

- A framework is to be provided to create a land acknowledgment that is particular and unique to each instance, personal, and not merely recited by rote.
- Recognize CPSM being located on the traditional lands of specific Indigenous Peoples. In Manitoba this is the Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene Peoples and the traditional home of the Red River Métis Peoples.
- Note applicable treaties (Winnipeg is located in Treaty 1 territory; Manitoba is located in Treaties 1-6, Treaty 5 Adhesion, and Treaty 10 land) and that we are all Treaty People.
- Note and reflect on the treaties being breached and not honoured resulting in numerous harms to Indigenous persons.
- Acknowledge the role of CPSM and registrants in harms to the health of Indigenous patients both historically and continuing through systemic racism. Honour your privilege in providing health care to Indigenous patients.
- Apology. This is dependent if the person providing the land acknowledgment is Indigenous or not.
- Commit to reconciliation and collaboration with Indigenous peoples and include specific actions for the future.

3 - Standard of Practice – Practicing Medicine to Prevent Indigenous Racism

- Recognize racism as professional misconduct
- Require medical practice to be safe for Indigenous patients
- See BC Practice Standard as one example. https://www.cpsbc.ca/files/pdf/PSG-Indigenous-Cultural-Safety-Cultural-Humility-and-Anti-racism.pdf
    - Self-reflective practice (it starts with me)
    - Building knowledge through education
    - Anti-racist practice (taking action)
    - Creating safe health care experiences
    - Person-led care (relational care)
    - Strength-based and trauma informed practice (looking below the surface).

4 a– Restorative Justice Approach to Complaints and Investigations

Restorative justice is an approach to justice that puts the emphasis on the wrong done to patients, and focusses on repairing or restoring relationships, fixing the damage that has been done and preventing further harm from occurring. Restorative justice is guided by *restorative values,* those that favour collaborative and consensus-based procedures over the adjudicative and adversarial forms that often characterize conventional regulatory procedures. When physicians who have caused injury are invited to truthfully acknowledge their wrongdoing, listen respectfully to patients they have hurt, and honour their duty to put things right again, significant steps are taken to restoring dignity and meeting the needs of all parties.

When appropriate, victims, offenders and community members may be involved in processes to:

- hold physicians accountable;
- support patients in their healing;
- provide an opportunity for participants to express their needs;
- reduce reoccurrence of incidents that led to bad care; and
- support the safe practice of practice of medicine by physician.

4 b – Create a Culture for Receiving and Addressing Complaints by Indigenous Patients

- Create a culture where Indigenous patients feel comfortable in making a complaint and being of the belief that the complaint will be addressed appropriately.
- Track Indigenous racism complaints, obtain optional demographic information from complainant, track outcomes
- Retain culturally appropriate staff and committee members to decide upon complaints of racism. Provide training for racism complaints.
- Retain an Indigenous support advisor to assist Indigenous patients in the complaints process
- Establish or clarify policies and procedures to specifically address complaints of racism

5 - Mandatory Indigenous-Specific Anti-Racism Training

- The course can be part of CPSM's commitment to implement the Truth and Reconciliation Commission's call to action, by requiring a baseline Indigenous intercultural competence of those working in healthcare.
- Registrants may be required to take an Indigenous intercultural course, which provides them with knowledge on the history of Indigenous-Crown relations, the history and legacy of residential schools, and how legislation regarding Indigenous peoples created the issues that reconciliation seeks to address.
- Required to understand the social construct that Indigenous people are living in and receiving medical care (ie community with life expectancy of 37, caregivers may be aunts/uncles/grandparents, multiple deaths of family members, intergenerational trauma from residential schools, rapidly falling life expectancy rate, etc)
- *The Path* course is one possibility. It has been mandated by the Law Society of Manitoba that is paying to have a Manitoba component. CPSM is investigating as to whether an Indigenous health care module is under development.
- The San'yas course adopted for Manitoba is another possibility, *Manitoba Indigenous Cultural Awareness Training*.
- Asynchronous learning to be considered given numbers – 4000+ registrants.

6a – Mentorship/Leadership at CPSM

- These are possible considerations:
    - Designate one specific Indigenous physician position on Council
    - Have Indigenous people in leadership roles at CPSM
    - Have culturally appropriate persons on committees (discipline especially)
    - Create a mentorship program at CPSM to assist physicians in providing medical care that is culturally safe and with cultural humility.
    - Continue to take a leadership role in the future on addressing Indigenous racism
    - Obtain resources/literature/podcasts to provide registrants on the subject of Indigenous racism
    - Implicit/unconscious bias training for CPSM staff/committee members/councillors

6b – Create Open Culture to Support Indigenous Physicians

- Create a culture that registrants are not fearful of making allegation of racism against another registrant/others or discussing/alleging racism in healthcare system etc.
- Recognize the duality of Western Medicine and Indigenous Medicine
- Recognize the duality of Indigenous physicians living in their culture and mainstream culture
- understand the social construct that Indigenous physicians are living in and providing medical care (ie community with life expectancy of 37, caregivers may be aunts/uncles/grandparents, multiple deaths of family members, intergenerational trauma from residential schools, rapidly falling life expectancy rate, etc.)
- recognize enormous demands on Indigenous physicians' time

7 - Definition of Indigenous Racism and Gather Examples of Racism by Medical Professionals

- In Plain Sight definition to be considered
- Examples can be used for educational purposes (see In Plain Sight report) and to use the experiences of the TRC Advisory Circle.

Next Steps

The TRC Advisory Circle recommended CPSM work on the first two items itself, and then have several members of the Advisory Circle review and provide comments to ensure it is appropriate. CPSM staff has been working on these items and will be meeting with members of the Advisory Circle to finalize.

Going forward, the TRC Advisory Circle will break into small groups to develop further recommendations to Council on each of Items 3-7.

These seven items are the preliminary recommendations of the TRC Advisory Circle. Council is being asked to pass a motion adopting the recommendations of the TRC Advisory Circle and direct further work be undertaken on each of the seven recommendations.

PUBLIC INTEREST RATIONALE

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

This has been addressed previously in various submissions to Council and remains highly pertinent today.

Mainstream Canadian society is slowly beginning to understand Indigenous racism – past and present – and how intergenerational trauma and social determinants affect the health of Indigenous peoples. The discovery of the many unmarked graves at residential schools across the country beginning in 2020 shocked Canadians That incident, built upon incidents like Jordan's principle, Joyce Echaquan being taunted by health care providers while dying, and stories about health care professionals gambling on blood alcohol levels of Indigenous patients in B.C.

All registrants are aware of the socio-economic determinants of health and the poor outcomes in healthcare experienced by Indigenous patients in the province. Until all practitioners recognize how medical care is impacted by Indigenous-specific racism, both in the care they provided and by the system, we will not see change.

CPSM has failed to regulate the medical profession on Indigenous-specific racism. Council recognized this by creating Indigenous-Specific racism to be addressed as a Strategic Organizational Priority. The seven recommendations form the initial core action items to address Indigenous-specific racism in the medical profession. These seven recommendations are required for CPSM to continue regulating the in the public interest – and ensuring Indigenous patients are at the forefront of the public interest. By approving, and then implementing these recommendations, CPSM and the medical profession will take one step towards the Truth and Reconciliation required in Canada.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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

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

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000-1661 PORTAGE AVENUE WINNIPEG, MANITOBA R3J 3T7
TELEPHONE: (204) 774-4344 FAX: (204) 774-0750
WEBSITE: www.cpsm.mb.ca

TRUTH AND RECONCILIATION – ADDRESSING ANTI-INDIGENOUS RACISM BY MEDICAL PRACTITIONERS
Terms of Reference
Advisory Circle

Note:

The term Indigenous is used to include First Nations, Metis, and Inuit in Manitoba.

Section 1: Background

Two recent high profile incidents in health care have launched the issue of racism in healthcare to the forefront – healthcare workers in BC ERs playing a game to guess the Blood Alcohol level of Indigenous patients and Quebec nurses taunting and mocking Joyce Echaquan while she was dying (which she recorded). This has led to a call by Indigenous organizations and others for the adoption of Joyce's principle.

> "Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health. Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health."

There are calls to action from the Truth and Reconciliation Commission and the Missing and Murdered Indigenous Women and Girls Inquiry which may place responsibilities on healthcare professional regulators. The BC Government launched an external investigation which released its report in November 2020, "In Plain Sight: Addressing Indigenous -Specific Racism and Discrimination in BC Health Care". Although the report is from British Columbia, much of that report may be applicable to Manitoba.

The Manitoba inquest into the 2008 death of Brian Sinclair exposed racism in the health care system and by healthcare providers and Manitoba, the RHAs, and the University have responded with various changes, yet anti-Indigenous racism still exists in healthcare. This is built upon a history of racism in Manitoba healthcare which includes inferior racialized and segregated hospitals and sanitoriums, amongst other institutional practices.

Jordan's Principle originated in Manitoba. It is a child-first legal requirement that aims to eliminate service inequities and delays for First Nations Children. It states that any public service ordinarily available to all other children must be made available to First Nation's children without

delay or denial. Jordan's Principle is named in honour of Jordan River Anderson, a young First Nations boy from Norway House Cree Nation in northern Manitoba, who spent his entire life in hospital while caught in a jurisdictional dispute between the governments of Canada and Manitoba, which both refused to pay for the in-home medical care necessary for Jordan to live in his home and community.

FMRAC recently has adopted, as one of its ongoing priorities, Addressing Racism in Physician Practice. At this point the Working Group is concentrating on Indigenous, Inuit, and Metis which is not to ignore the racism that negatively affects others and is highlighted by the Black Lives Matters movement.

CPSM was an attendee at the two-day January summit hosted by the federal government on "Addressing Anti-Indigenous Racism in Canada's Health Care Systems". At that summit, the federal government announced the National Consortium for Indigenous Medical Education and the commitment to the development of Indigenous health care legislation and a federal Indigenous health care authority. Both were very well received.

In Manitoba, there are numerous recent initiatives launched by the University to address anti-indigenous racism by medical practitioners:

- The Undergraduate Medical Education Program has an 80 hour requirement for culturally safe medical practice through a special curriculum
- The Postgraduate Medical Education Program is currently creating requirements for culturally safe medical practice through a special curriculum
- The Faculty of Medicine has created a Truth and Reconciliation strategy which it is working on implementing
- The University Faculty of Health Sciences has a Disruption of all Forms of Racism Policy, which is the first passed by any faculty or post-secondary institution in Canada

The new physicians from the University of Manitoba will be graduating with significant anti-racism training. However, physicians from other areas of Canada may not have this level of training, and those who are internationally trained and or new to Canada will have no such training. Similarly, those physicians already practicing in Manitoba may not have such training. It is important to ensure all physicians in Manitoba have some degree of training in anti-Indigenous racism to keep their knowledge and skills current.

Finally, the *Code of Ethics and Professionalism* contains the following:

> 43 Commit to collaborative and respectful relationships with Indigenous patients and communities through efforts to understand and implement the recommendations relevant to health care made in the report of the Truth and Reconciliation Commission of Canada.

Section 2: Purpose

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

Section 3: Leadership and Membership

The Committee will be led by Dr. Lisa Monkman.

The Advisory Circle Membership is to be led by and include representatives from the Indigenous physicians, Indigenous CPSM members, and indigenous community members (i.e. scholars, leaders, elders, traditional knowledge keepers, and traditional healers). Other affiliated members will include non-Indigenous members such as the Associate Dean – Continuing Competency and Assessment at the College of Medicine and others. Support will be provided from the CPSM Staff.

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

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

COUNCIL MEETING –SEPTEMBER 29, 2022

NOTICE OF MOTION FOR APPROVAL

SUBJECT: **Truth and Reconciliation Commission: Addressing Indigenous Racism in Medical Practice Advisory Circle**

- **CPSM Apology and Statement**

BACKGROUND:

Addressing Indigenous Racism in Medical Practice is a Strategic Organizational Priority. The Truth and Reconciliation (TRC) Advisory Circle has met and made seven recommendations to Council to further this priority.

Apology and Statement

Please read this short and interesting article from the Harvard Business Review, "The Organizational Apology". Though written largely for corporations, much of it is applicable to both an organization such as CPSM and the nature of our apology. https://hbr.org/2015/09/the-organizational-apology

Much of what is discussed in this article will address many of the considerations that went into the drafting and issuance of the Apology and Statement including how to determine if an apology is necessary:

- Was there a violation, whether real or perceived?
- Was the violation core or non-core?
- How will the public act? (In this case Indigenous persons)
- Is the organization willing to commit to change?

The article also sets out "The Right Way" to Apologize.

The CPSM Apology and Statement is an apology from CPSM to Indigenous Persons in Manitoba – First Nations, Inuit, and Métis. It is to be signed by both the President and Registrar. It is to be approved by Council recognizing the importance of the contents of the document and to abide by best practices in governance. According to the Harvard Business Review article, "for core violations, the "what" has to show a tremendous commitment to change, the "who" has to be senior leaders, the "when" has to be fast, the "where" has to be high profile, and the "how" must be deeply sincere and demonstrate empathy."

The Apology and Statement must express candour, remorse, and a commitment to change – and be sincere.

The Apology and Statement has been shared with a sub-group of the Advisory Circle. They provided comments which were incorporated. It has also been shared with the other members of the TRC Advisory Circle.

It is one thing to prepare an apology, but it is another thing to issue the apology, especially when it is from an organization to a large portion of the population. A plan for delivering the Apology purposefully is being developed, including a timeline, community outreach, and the proper channels. CPSM has been guided by the TRC Advisory Circle sub-group and they have recommended CPSM leaders meet with groups of different Indigenous leaders and organizations to apologize in person. Once that is done, then the Apology will be made public (including sharing it with registrants). Issuing the apology before making it public is critical as the people to whom CPSM is apologizing must hear it directly from CPSM.

It is absolutely critical for CPSM to first deliver the Apology and Statement in person to the First Nations, Métis, and Inuit Peoples. For this reason, the CPSM Apology and Statement itself is not included in this document. It will be shared with Councillors separately to review. While Council always strives for transparency, CPSM will not make the Apology public before it is delivered to the intended audience.

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

Apologizing is tough - whether on a personal or organizational level. CPSM is admitting to a failure – a failure to regulate the medical profession over 150 years on Indigenous-specific racism that has caused much harm to First Nations, Métis, and Inuit Peoples. Apologizing is the right thing to do and is the first step in our pursuit of reconciliation.

As part of Truth and Reconciliation, organizations should review their historical and current practices and fully address them when found to be wrong. Then, changes for the future must be identified and put into place. The legislature has placed great trust in CPSM to regulate the medical profession in the public interest. It has failed to do so in regard to Indigenous-specific racism in the medical profession. This has contributed to poor health outcomes, including death.

If CPSM fails to apologize effectively, then this will further damage the relationship with First Nations, Métis, and Inuit people. This failure will further undermine the trust that is required for CPSM to continue to regulate the medical profession in the public interest.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON SEPTEMBER 29, 2022, DR. NADER SHENOUDA, PRESIDENT-ELECT, WILL MOVE THAT:

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

COUNCIL MEETING – SEPTEMBER 29, 2022

BRIEFING NOTE

SUBJECT: Registration Department

BACKGROUND:

The Registration Department is a core function of CPSM and is responsible for registering physicians, clinical assistants, physician assistants, residents and medical and physician assistant students on the Register of Regulated Members or Register of Regulated Associate Members.

Ms Jo-Ell Stevenson, Director, Registration Department will provide a presentation to Council on the registration process. This process has many layers and challenges and includes:

- The type of delays with applications and most common errors and omissions
- CPSM liaison with external organizations and turn-around times
- The process of working with registrants throughout the process to full registration

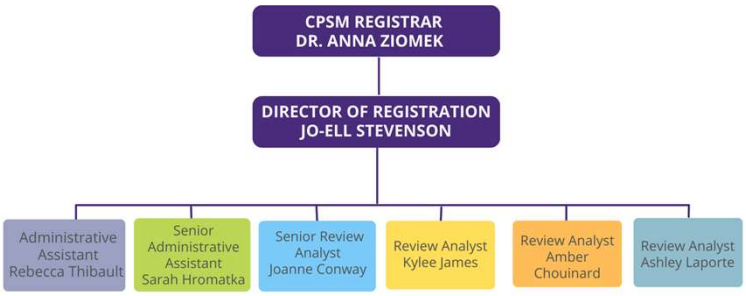
REGISTRATION PROCESS

Presented by: Jo-Ell Stevenson, Director of Registration

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

1

Registration Department



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2

Categories of Registration

Regulated Member Register List of Membership Classes:

- Full (practising) class
- Full (non-practising) class

- Provisional (academic – s. 181 faculty) class
- Provisional (academic – visit professor) class
- Provisional (post-certification trainee) class
- Provisional (specialty practice-limited) class
- Provisional (family practice-limited) class
- Provisional (MPAP) class
- Provisional (restricted purpose) class
- Provisional (public health officer) class
- Provisional (temporary locum) class
- Provisional (transitional) class
- Provisional (non-practising) class

slide 2

3

Categories of Registration

Regulated Associate Member Register List of Membership Classes

- Assessment candidate (specialty practice) class
- Assessment candidate (family practice) class
- Assessment candidate (re-entry to practice) class

- Educational (medical student) class
- Educational (physician assistant student) class
- Educational (resident) class
- Educational (resident-limited) class
- Educational (visiting student) class
- Educational (non-practising) class

- Physician assistant (full) class
- Physician assistant (restricted purpose) class
- Physician assistant (academic – s. 181 faculty) class
- Physician assistant (non-practising) class

- Clinical assistant (full) class
- Clinical assistant (non-practising) class

- Retired (physician assistant) class
- Retired (clinical assistant) class

slide 3

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Applications Received

Between April 1, 2021 – July 1, 2022

Membership Class	Applications Received During This Time Period
Clinical Assistant	66
Educational – Medical Student	127
Educational – Physician Assistant Student	16
Educational - Resident	199
Educational – Visiting Student	70
Physician Assistant	15
Regulated Member - Full	155
Regulated Member - Provisional	183
Regulated Member – Provisional PCT	20
Regulated Member – Provisional s181	1
TOTAL	**852**

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Applications Received and Registration Issued

Between April 1, 2021 – July 1, 2022

Membership Class	Applications Received During This Time Period	Applicants Registered During Time Period
Clinical Assistant	66	33
Educational – Medical Student	127	110
Educational – Physician Assistant Student	16	13
Educational - Resident	199	180
Educational – Visiting Student	70	44
Physician Assistant	15	15
Regulated Member - Full	155	92
Regulated Member - Provisional	183	38
Regulated Member – Provisional PCT	20	12
Regulated Member – Provisional s181	1	1
TOTAL	852	538

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Applications Received, Registration Issued, and Referrals to the Physician Health Program

Between April 1, 2021 – July 1, 2022

Membership Class	Applications Received During This Time Period	Applicants Registered During Time Period	Referrals to Physician Health Program
Clinical Assistant	66	33	1
Educational – Medical Student	127	110	0
Educational – Physician Assistant Student	16	13	0
Educational - Resident	199	180	1
Educational – Visiting Student	70	44	2
Physician Assistant	15	15	0
Regulated Member - Full	155	92	7
Regulated Member - Provisional	183	38	1
Regulated Member – Provisional PCT	20	12	0
Regulated Member – Provisional s181	1	1	0
TOTAL	**852**	**538**	**12**

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Civil Actions, Criminal Actions and Complaints

Between April 1, 2021 – July 1, 2022

Membership Class	Civil Actions	Criminal Actions	Complaints
Educational - Resident	0	1	2
Regulated Member - Full	7	3	6
Regulated Member - Provisional	3	0	7

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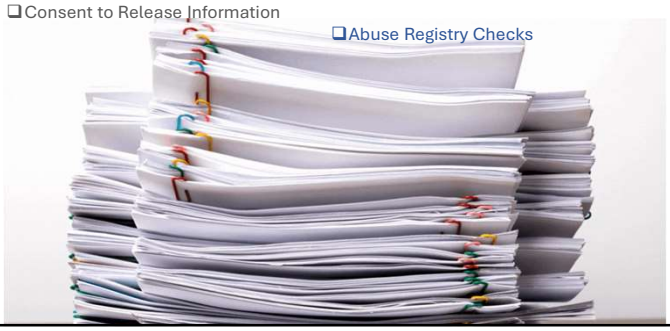
Documentation Required

- ❑ Completed Application for Medical Registration (AMR) (*PhysiciansApply)*
- ❑ Fees: documentation, registration, certificate of practice, specialist
- ❑ Reference forms
- ❑ Identity (valid passport and PRC or valid work permit)
- ❑ MINC
- ❑ Consent to Release Information
- ❑ English Language Proficiency (ELP)
- ❑ Professional liability declaration (CMPA)
- ❑ Satisfactory completion of fellowship training programs
- ❑ CRC
- ❑ Good Standing from all jurisdictions in which applicant was registered or evidence of good standing from medical school or training programs
- ❑ Abuse Registry Checks



- ❑ Documents from Physiciansapply:
  - ❑ Medical Diploma
  - ❑ LMCC
  - ❑ Internship document
  - ❑ Postgraduate training
  - ❑ Specialty certificates
  - ❑ Photo
  - ❑ Evidence of identity
- ❑ Complaint/ investigation particulars and correspondence – *if applicable*
- ❑ Criminal conviction particulars – *if applicable*
- ❑ Civil action particulars – *if applicable*
- ❑ Legal name change document - *if applicable*
- ❑ PGME Fellowship training program package (*for PCT Registrants*)

Blue = *If these documents are not received in time for registration, applicant can be registered with a signed undertaking*
Orange = *Documents from PhysiciansApply.ca*

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Documentation Required for Canadian Certifications

- ❑ Certificate of medical school graduation form
- ❑ Medical diploma – copy required if Canadian (*prior to 2018; after 2018 diploma source verified at Physiciansapply account)*
- ❑ Satisfactory completion of recent residency
- ❑ Royal College certification/Royal College eligibility/American Board certification
- ❑ CCFP certification/CCFP eligibility
- ❑ LMCC certification/MCCQE1 certification

Specialist Register Application

- ❑ Specialist register application form
- ❑ Specialist register fees

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Additional Documentation Required for Provisional Registration

- ❑Practice supervisor approved by CPSM and signed undertaking
- ❑Signed undertaking by the Provisional registrant
- ❑Mentor (name provided by region to University, then to CPSM for approval) – *if applicable*
- ❑Minister's Certificate
- ❑Letter for immigration purposes – *if required*
- ❑Royal College certification/Royal College eligibility/American Board certification
- ❑CCFP Certification/CCFP eligibility
- ❑LMCC Certification/MCCQE1 certification
- ❑American Board eligibility

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Additional Documentation Required for Physician Assistants and Clinical Assistants

- ❑National Assessment Collaboration (NAC) assessment – Physician Assistant and Clinical Assistants
- ❑Contract of Supervision - Physician Assistant and Clinical Assistants
- ❑Practice description - Physician Assistant and Clinical Assistants
- ❑NCC PA certification for US trained Physician Assistants
- ❑Deans Letter for Physician Assistants
- ❑Copy of Physician Assistant diplomas
- ❑Certification of PA School – Physician Assistants
- ❑Completion of Training Letter for Physician Assistant Students from Master of PA Studies Office (MB Grads Only)

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Reasons for Delays - Applicant

- Discloses open or previous complaint with another licensing authority
- Documents not shared or submitted at PhysiciansApply
- Documents have not been translated at PhysiciansApply
- Does not hold a postgraduate training document from the country of origin
- Missing items such as CRC and Abuse Checks undertaking, evidence of identity, or practice location not submitted or balance of documentation fee remaining
- Different name on application then medical diploma and training documents (name discrepancy)
- Evidence of Good Standing includes complaint/investigation information which was not disclosed on application
- Omits information or includes incorrect information on AMR
- Work permit not obtained

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Reasons for Delays - External

- Evidence of Good Standing includes complaint/investigation information which was not disclosed on application
- Reference Form includes information which may or may not have been disclosed by applicant
- Minister's Certificate sent to Manitoba Health for approval/signature
- Practice supervisor or mentor delays
- Evidence of practice from employers (*required for PRA MB-FP Applicant*s)
- Work permit (*or LMIA – Labor Market Impact Assessment*)
- Request from University or Departments for Expedited Registration

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Reasons for Delays – CPSM/Legal

- Application requires legal advice
- Application requires approval from Registrar to proceed based on documentation/evidence received

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External Stakeholders

The role external stakeholders play in the registration process:

Manitoba Health
- Signed Minister Certificates
- Practice supervisor undertakings
- Confirmation of employment

University of Manitoba, International Medical Graduate Program
- Confirmation of assessment(s)
- Completion of training program letters
- Completion of assessment letters
- assigning and training mentors

Regional Health Authorities
- Change in practice supervisor
- Confirmation of practice supervisor
- Confirmation of mentor

Licensing Authorities Across Canada
- Receiving COPCs from other jurisdictions
- Confirmation regarding information on COPCs
- Confirmation on the type of registration issued – specific to CFTA

Postgraduate Medical Education office
- Start of LOA's – CPSM is not notified in a timely manner
- End of LOA's – CPSM is not notified in a timely manner
- Revised completion of training dates
- Completion of training letters

- Medical Council of Canada/Physiciansapply
- College of Family Physicians of Canada
- Royal College of Physicians and Surgeons of Canada

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Manitoba Licensure Program for International Medical Graduates (MLPIMG)

- Application to IMG Program (1 September)
- Eligible Candidates are Ranked and Interviewed by IMG Program (October/November)
- Names (30) are sent to **CPSM to Verify Training Requirements Met** (December/January)
- Manitoba Health and Regional Health Authority Interviews/Sponsorship (March/April)
- CPSM Notified of Top 20 Selected (April/May) Associate Members, Educational Residents (May/June)

- **CPSM to Register Top 20 Applicants** as Regulated Start program 1 July

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Practice Ready Assessments

Family Practice (PRA MB-FP)

- Application to IMG Program
- Eligible Candidates are Ranked and Interviewed by IMG Program
- Eligible candidates sit the Therapeutic Decision Making (TDM)Exam
- Names are emailed to CPSM; must complete AMR and supporting documents
- CPSM to verify training requirements met
- Manitoba Health and Regional Health Authority Interviews/Sponsorship
- If sponsorship secured, Regulated Associate Member, Assessment Candidate, Family Practice Registration issued for PRA
- If successful on PRA, Provisional Registration issued
- College of Family Physicians of Canada (CCFP) and LMCC OR MPAP required for Full (Practising) Class Registration

Specialty Practice (PRA MB-SP)

- AMR submitted to CPSM (anytime)
- CPSM to review if examination/training requirements and English Language Proficiency met
- If meets requirements, name referred to Manitoba Health and University of Manitoba IMG Program for PRA
- If sponsorship secured, Regulated Associate Member, Assessment Candidate Specialty Practice Registration issued for PRA
- If successful on PRA, Provisional Registration issued
- Royal College Certification and LMCC OR MPAP required for Full (Practising) Class Registration

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Provisional Registrants – Meeting Requirements for Full (Practising) Class

- Must meet requirements within 5 years of the date of Provisional Registration
  - Family Practice – CCFP and LMCC
    - CCFP exams are only offered in Spring (April) and Fall (October)
    - MCCQEI (LMCC) – offered 4 session times/year
  - Specialty Practice – Royal College Certification and LMCC
    - Royal College exams are offered in Spring or Fall, depending on specialty
    - MCCQEI (LMCC) – offered 4 session times/year
- Members may contact CPSM when they have obtained the examinations
- For most part, Registration must follow-up with Provisional Registrants

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Registration - Working Groups and Additional Duties

- Fairness Practices Registration Office (FRPO)
- AMR Working Group – Medical
- FMRAC Registration Group
- MCC National Physician Registry Working Group
- Medical Corporations
- Annual Renewals

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Manitoba Practice Assessment Program (MPAP)

Additional Route to Full (Practising) Class Registration

- Registrants must attempt all eligible examinations
  - MCCQEI
  - 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

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QUESTIONS?

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THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – SEPTEMBER 29, 2022

FOR INFORMATION

SUBJECT: Fast Track Registration

ISSUE: Permitting physicians with full licensure in another Canadian jurisdiction to register with CPSM via a fast-track registration process.

BACKGROUND:

CPSM and other Canadian Medical Regulatory Authorities ("CMRAs") have developed model standards for registration to practice medicine. Each Canadian province and territory have established substantially similar requirements for full licensure to practice medicine within their jurisdiction. The Federation of Medical Regulatory Authorities of Canada attempted to introduce fast track registration nationally, but not all jurisdictions were interested. Several CMRAs then tried jointly but were also unable to reach final consensus and were delayed by the pandemic. CPSBC recently initiated Fast Track recognizing increasing mobility of physicians.

In Manitoba, registration criteria for the medical profession are prescribed in detail under *The Regulated Health Professions Act* and *CPSM General Regulation*. These criteria are lengthy, requiring significant information and records for any applicant seeking to practice in Manitoba. Required records may be dated and difficult to obtain from international sources and include medical school diplomas, certificates of postgraduate studies, and certificates of conduct from all jurisdictions in which they have practiced. A Fast Track process would reduce the amount of information and records required in the registration process in appropriate circumstances.

ANALYSIS

Purpose:

Fast Track Registration is sought for physicians with a full, unrestricted license for independent practice in good standing with another CMRA. To qualify for Fast Track, it is proposed physicians would need to be up to date with continuing professional development hours and must have a clear Certificate of Professional Conduct ("COPC") from the other CMRA.

A Fast Track process would expedite registering physicians in Manitoba by reducing the amount of information and records required in the application process. Reduced requirements relate to information and records which another CMRA can reasonably be trusted to have already properly validated. It is important to note that the qualifications for registration remain the same; the

process is merely accelerated by relying upon the validation and verification process done by another CMRA where the applicant has independently practiced.

It is anticipated Fast Track would support labour mobility and result in a more efficient and timely application process, reducing the administrative burden on applicant physicians. Fast Track is expected to result in more physicians practicing medicine in Manitoba by reducing the time and the red tape associated with the usual registration process.

Statutory Context:

1. Council is required to make regulations respecting registration including establishing the qualifications, experience, and other requirements to be met by applicants for registration (RHPA subsections 221(1)(g) – (o)). Council has already made regulations which have been passed by Cabinet. These regulations establish the qualifications, experience, and other requirements for registration. These criteria can be applied and interpreted to implement Fast Track (*CPSM General Regulation*, sections 3.2, 3.7, and 3.8).

2. *CPSM General Regulation* subsection 3.2(1) establishes requirements for the contents of an initial application for registration, including:
    - a signed application in the approved form and the applicable fee,
    - proof of identity (i.e., government issued photo identification),
    - a passport size photo of the applicant,
    - Medical Identification Number (MINC),
    - a list of jurisdictions where the applicant was or is authorized to practice medicine or any other regulated profession,
    - satisfactory evidence of good standing in each jurisdiction where authorized to practice a regulated profession,
    - satisfactory criminal/child abuse/vulnerable persons record checks,
    - specific provisions for the class of registration (noting s. 8 for full registration),
    - information respecting professional conduct history and character, and
    - a satisfactory description of professional practice – recent past and proposed.

3. Criteria under subsection 3.2(1) are generally qualified with the terms "*satisfactory*" or "*approved*". The term approved, for the purpose of the *CPSM General Regulation*, means approved by the Council except where the approval is indicated to be given by the Registrar or other person or body. The term "satisfactory" means satisfactory to the Registrar. In other words, the Registrar can decide what is satisfactory and Council can approve the application form. Note that administrative discretion in this regard is always constrained by the statutory scheme and the rule of law.

4. Section 3.7. of the *CPSM General Regulation* is a catch all section respecting the review of the totality of information and records obtained in the application process for regulated

membership. There is nothing specific listed in terms of what the applicant must provide. Section 3.7 requires an applicant to establish that:

- They do not or have not had a physical or mental condition that could impair their ability to practice medicine.
- Their past and present conduct affords reasonable grounds that they will practice competently, and with decency, honesty, and integrity.
- They meet the approved English language fluency criteria.
- They are legally entitled to work in Canada.

5. Section 3.8 requires the applicant to establish that they hold (amongst other items):
    - a qualifying degree in medicine (UGME),
    - LMCC and CCFP, FRCPC, or CCMQ (or alt. process such as MPAP) (PGME), and
    - and other various qualifications (i.e., CPD and currency).

6. The *Canadian Free Trade Agreement* between the provinces establishes labour mobility provisions and obligations that state that certified workers must be recognized as qualified to work by a regulatory body in another province that regulates that occupation, without having to go through significant additional training, work experience, examination, or assessment unless an exception has been made by government. The *Canadian Free Trade Agreement* is applicable to the medical profession and CPSM. No exceptions have been made.

7. In essence, section 3.8 is overridden by the *Canadian Free Trade Agreement* regarding physicians who will qualify for Fast Track (i.e., those who are fully registered with another CMRA who are active in practice, including up to date in their continuing professional development).

Based upon the above, Fast Track can be implemented under the current regulations, and amendments to the regulation are not required.

Changes in application process (Regular Application vis-à-vis Fast Track)

Currently CPSM gathers and verifies all information and records required for registration. Fast Track is intended to eliminate requirements that duplicate extensive gathering and verification of information and records previously undertaken by another CMRA in which the applicant physician is currently practicing medicine in good standing. For the most part, this information is already gathered by another CMRA and is listed in the COPC issued by the jurisdiction in which they are currently registered. Information to satisfy the requirements of subsection 3.2(1) of the *CPSM General Regulation* would also be declared in the applicant physician's application form.

Fast Track would mean the applicant need not complete a full Application for Medical Registration through 'physiciansapply.ca'. CPSM would not seek original education and training documents through 'physiciansapply.ca' or the applicant. This documentation would have been

obtained by another CMRA at some point for the candidate to have been initially registered in Canada. CPSM would obtain only one COPC from a qualifying CMRA and one CRC from that jurisdiction.

In terms of information, as compared to the full Application for Medical Registration (physiciansapply.ca), the Fast Track application asks for less or no detailed information about the following:

1. UGME,
2. PGME (Canadian or international training and credentials),
3. exams, assessments, and certifications, or
4. details about practice experience that is more than three years past.

The COPC from the other jurisdiction will contain adequate information about the above.

IMPLEMENTING FAST TRACK REGISTRATION:

There are several items required to implement fast track registration:

1. The Executive Committee must approve an application form with the required information.

2. The Registrar must establish policies respecting what will be satisfactory for the purpose of Fast Track, including what will be:
    a. *"Satisfactory evidence of good standing in each jurisdiction in which the applicant is or was authorized to practise medicine or any other regulated profession or occupation*" (see clause 6 at ss. 3.2(1) of the CPSM Gen. Reg.), and
    b. "*A satisfactory criminal record check, child abuse registry check and adult abuse registry check*" (see clause 7).

The Executive Committee meets in early October and this will be included on its agenda. If approved, then it will be implemented immediately.

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*" (see RHPA ss. 10(1))

There is enormous demand for physicians in Manitoba and this is reflected partially in the huge numbers of people who do not have a family doctor, the lengthy waits for consults with specialists, and the waiting lists for procedures.

Taken together, the RHPA (see s. 1 and ss 32(3)), the CPSM General Regulation (see s. 4.8), applicable provisions of *The Labour Mobility Act* and the CFTA (see Chapter 7), and *The Fair Registration Practices in Regulated Professions Act* make clear CPSM is mandated to create and foster a fair, efficient and timely process for the registration of qualified applicants.

Given the increasing mobility of physicians, this will be attractive to quickly register with reduced red tape. This might be especially advantageous for those travelling to do locums in Manitoba, or for those seeking additional surgical slates (including in Northern Manitoba). With the physician shortage in Manitoba, this may slightly alleviate some wait times and should lead to more physicians registering to practice in Manitoba due to the ease of fast-track registration.

COUNCIL MEETING –SEPTEMBER 29, 2022

FOR INFORMATION

SUBJECT: Strategic Organizational Priorities

BACKGROUND:

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

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

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

There are 31 Standards of Practice, 21 Practice Directions, and 9 Council Policies. Attached is a multiyear plan to review all documents.

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
• 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

Performance Metrics Creation

CPSM has reviewed the Performance Metrics of CPSBC and met with their Registrar for an explanation and discussion. Alberta has just retained a consultant to create their performance metrics. CPSM will likely utilize much of the CPSBC approach. Further details and a presentation will be provided at the December Council meeting.

Standards of Practice Review

At this meeting Council is being asked to approve two Standards (Female Genital Cutting – Mutilation and Seatbelt/Helmet Exemptions). These are two smaller Standards and are being updated without a Working Group and without a consultation period. When new Standards are created a consultation with stakeholders, registrants, and the public is required. Revisions to Standards only require consultation at the discretion of Council. These two Standards are being reviewed as part of a proof of concept for this type of review.

Standards of Practice Multi-Year Review Cycle

Title	Level of Review	Origin Date	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Advertising	Medium	1-Jan-19				X			
Authorizing Cannabis for Medical Purposes	Medium	1-Nov-20		✓					
Bloodborne Pathogens	Small	1-Jan-19					X		
Collaborative Care	Large	1-Jan-19						X	
Confidentiality and Privacy	Medium	1-Jan-19							X
Conflict of Interest	Medium	1-Jan-19							X
Continuing Disclosure Requirements and Notices of Changes for Members Matters	Small	1-Jan-19						X	
Definitions	Small	1-Jan-19					X		
Duty to Assist in an Emergency	Small	1-Jan-19						X	
Duty to Report Self, Colleagues, or Patients	Medium	1-Jul-21			✓				
Exercise Cardiac Stress Testing	Medium	1-Jun-22			✓				
Female Genital Cutting/Mutilation	Small	1-Jan-19				X			
Good Medical Care	Large	1-Jan-19					X		
~~Home Births~~ Repealed	Small	1-Jan-19			✓				
Medical Assistance in Dying (MAID)	Large	1-Jun-19			✓				
Patient Records - Documentation in Patient Records	Large	15-Feb-22			✓				
Patient Records - Maintenance of Patient Records in all Settings	Large	15-Feb-22			✓				
~~Patient Records~~ Repealed	Large	1-Jun-19							
Performing Office Based Procedures	Large	31-Jan-22			✓				
Practice Environment	Large	1-Jan-19						X	
Practice Management	Large	1-Jan-19						X	
Prescribing Benzodiazepines & Z-Drugs	Large	1-Nov-20		✓					
Prescribing Opioids	Large	1-Jan-19	✓						
Prescribing Requirements	Large	1-Jan-19				X	X		
Professional Responsibilities in Undergraduate & Postgraduate Medical Education	Large	1-Jan-19				X			
Research	Small	1-Jan-19						X	
Seatbelt/Helmet Exceptions	Small	1-Jan-19				X			
~~Self-Reporting to the College~~ Repealed	Medium	1-Jan-19			✓				
Sexual Boundaries with Patients, Former Patients & Interdependent Persons	Large	31-Mar-21		✓					
Social Media - New	Small	TBD				X			
Treating of Self and Family Members	Small	1-Jan-19							X
Virtual Medicine	Large	1-Nov-21			✓				
Volume of Service	Medium	1-Jan-19							X
Withholding & Withdrawing Life-Sustaining Treatment	Large	1-Jan-19							X

Practice Directions Multi-Year Review Cycle

Title	Level of Review	Origin Date	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Appeals from Investigation Committee Decisions	Medium	23-Mar-22			✓				
Appeals Pursuant to Section 38 of the RHPA	Small	1-Jan-19							X
Cancellation of Registration or Certificate of Practice Pursuant to S48 of the RHPA	Small	1-Jan-19				X			
Complaints Investigations - Resolving Conflict & CPSM's Complaints & Investigations Processes	Large	8-Dec-21			✓				
Continuing Professional Development	Small	1-Jan-19						X	
Decisions Regarding Permits for Health Profession Corporations & Related Appeals	Medium	1-Jan-19						X	
Dispensing Physicians	Small	1-Jan-19				X	X		
EKG Interpretation and Billing Eligibility	Small	1-Jan-19		✓					
Electronic Transmission of Prescriptions	Small	1-Jan-19				X	X		
Facsimile Transmission of Prescriptions	Small	1-Jan-19				X	X		
Interprofessional Collaborative Care	Large	21-Jun-19							X
Manitoba Practice Assessment Program Summative Assessment	Large	1-Jan-19				X			
Manitoba Prescribing Practices Program (M3P)	Medium	1-Jan-19				X	X		
Medical Corporations and Clinic Names	Large	1-Jan-19						X	
Prescribing Methadone or Suboxone	Medium	1-Jan-19							X
Prescribing Practices: Doctor/Pharmacist Relationships	Medium	1-Jan-19				X	X		
Qualifications and Registration	Large	1-Jan-19				X			
Reinstatement Application	Medium	1-Jan-19				X			
Rural, Remote, and Underserved Populations: Access to Prescribed Drugs	Medium	1-Jan-19				X	X		
Specialist Register Procedures During COVID-9 Pandemic	Small	9-Apr-20	✓						

Policies Multi-Year Review Cycle

Title	Level of Review	Origin Date	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Age Triggered Quality Audit	Small	9-Dec-20		✓					
Appeal Guidelines of IC Decisions	Small	1-Jan-19						X	
Ends	Small	1-Jan-19					X		
Financial Management	Medium	1-Jan-19							X
Governance Policy	Large	1-Jan-19						X	
Physician Health Program	Large	16-Sep-15							X
Prescribing Practices Program	Medium	19-Mar-21		✓					
Privacy Policy	Medium	13-Mar-20	✓						
Registrar Duties and Authority	Large	1-Jan-19				X			

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					**Delayed**	The working group is proceeding with various initiatives under this overall review.
Truth & Reconciliation - Addressing Anti-Indigenous Racism by Medical Practitioners	21-Sep-21		Formed					On Track	The Advisory Circle has met 7 times to date. There are 7 recommendations for Council to consider at the September 2022 meeting.
Episodic Care, House Calls, Walk-Iin Clinics - Standard of Practice	21-Sep-21	21-Jun-21	Formed	22-Mar-21	22-Apr-21	22-Jun-21	22-Jul-21	On Track	The Standard is before Council at the September 2022 meeting.
Quality of Care as Idenitity of CPSM	22-Jun-22							Not Started	Just approved at June 22 Council
Performance Metrics Creation	22-Jun-22							Not Started	Just approved at June 22 Council
Review of SofP/PD/Bylaws/Policies	22-Jun-22							On Track	Just approved at June 22 Council

Last revised: September 12, 2022

COUNCIL MEETING – SEPTEMBER 29, 2022
COMMITTEE REPORTS
FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The Executive Committee met in person, with a few members joining virtually, on July 13 and August 24, 2022, and an electronic meeting on July 5, 2022.

The July 5, 2022 electronic meeting was to approve Practice Auditors. The meeting on July 13, 2022 was to review CPSM Strategic Organizational Priorities and discuss various other current CPSM issues. The meeting on August 24, 2022 was to review the September 2022 Council Agenda, and various other matters were discussed.

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

FINANCE, AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

The Finance, Audit & Risk Management Committee meets three times a year. The first meeting of the year is scheduled in November after CPSM has reached the first six months of annual operations. As such, there is nothing to report for the September 29, 2022 Council Meeting.

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

PROGRAM REVIEW COMMITTEE REPORT:

Diagnostic Facilities:

- Work continues to reduce the back-log of inspections resulting from COVID-19 pandemic restrictions.
- 3 new diagnostic imaging sites have been accredited to open.

Non-Hospital Medical Surgical Facilities:

- The CPSM NHMSF Standards have been approved for use. These standards were adapted from CPSA's NHSF.
- Accreditation inspections have begun using the new NHMSF Standards.

- The new Adverse Patient Outcome (APO) process has been implemented. Work continues to refine this process.
- Work continues with the NHMSFs to develop a standardized list of procedures and names.

Work has begun with CPSM IT to move MANQAP data (diagnostic facilities and NHMSF) to the CPSM Portal.

Respectfully submitted
Ms Leanne Penny
Chair, Program Review Committee

COMPLAINTS COMMITTEE REPORT:

Since the June 22nd Council meeting CC did not meet over the summer. The next scheduled meeting will be held on September 16, 2022

Respectfully submitted
Dr. Norman McLean
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

Dear Council, I hope you've all enjoyed a good summer.

The Investigation Committee has met three times since the start of June.

On June 15, 2022 we reviewed 17 matters. The outcomes of these investigations were as follows:
5 cases resulted in a letter of criticism
1 case resulted in a letter of advice
9 cases resulted in a decision of no further action
1 case resulted in a physician agreeing to an undertaking
1 case resulted in a physician agreeing to a censure.

At a special meeting on June 30, 2022 we reviewed 3 matters. The outcomes of those investigations were:
2 cases resulted in letters of criticism
1 case resulted in a remediation plan for the physician involved

On September 7, 2022 we reviewed 14 matters. The outcomes were as follows:
6 cases resulted in no further action
4 cases resulted in letters of criticism
2 cases resulted in letters of advice
1 case was deferred pending the need to acquire further information
1 case was referred to inquiry after the physician rejected our censure

As of today, there are 159 outstanding investigation cases.

I would like to thank Dr Charles Penner for his outstanding contributions to the Investigation Committee over the past year. We wish him the best as he joins the Executive and Financial Audit and Risk Management Committees.

We have had the pleasure of welcoming several External Members to our Committee and to date, the contributions of these members has been excellent.

We continue to meet monthly and will have three more meetings before our next Council meeting in December.

Respectfully submitted
Dr. Kevin Convery
Chair, Investigations Committee

STANDARDS COMMITTEE REPORT:

Central Standards Committee (CSC) Activities 2022

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

AGE TRIGGERED/REFERRED AUDITS REVIEWED IN 2022

The CSC reviewed:

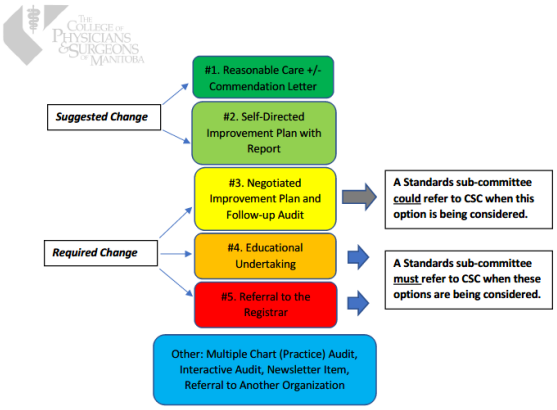
2 age triggered audits and 6 referred audits at the February 4, 2022, meeting.

4 age triggered audits and 1 referred audit at the April 8, 2022, meeting. The committee was also informed of 3 Quality Improvement Program participants who were direct Referrals to the Registrar at the discretion of the Chair due to non-compliance.
5 age triggered audits and 3 referred audits at the June 3, 2022, meeting.

In total, 24 audits have been reviewed by the CSC since January of 2022.

The following were the outcomes determined from those meetings.

7	#1 outcomes
6	#2 outcomes
4	#3 outcomes
4	#4 outcomes
3	#5 outcomes
	Other – Interactive Audit
24	Total



Standards Sub-Committee Reporting

The Central Standards Committee has been receiving quarterly and annual reports from the various Standards Committees within the province. To date in 2022, the CSC has reviewed reports from:

- Child Health Standards Committee Quarterly and Annual Reports
- Maternal & Perinatal Standards Committee Annual Report
- Eden Mental Health Centre Quarterly Report and Annual Report
- Boundary Trails Health Centre Quarterly Report
- Portage Area Standards Committee Quarterly Report
- Provincial Orthopedic Standards Committee Quarterly Report
- CancerCare Manitoba Standards Committee Quarterly Report

Respectfully submitted
Dr. Roger Suss
Chair, Central Standards Committee

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – SEPTEMBER 29, 2022

ITEM FOR INFORMATION

SUBJECT: Registrar/CEO's Report

COVID-19 Pandemic

While the COVID-19 pandemic has slowed, medical professionals are facing increasing challenges in delivering quality health care. This is impacted by health care system constraints and burn-out and fatigue by individual practitioners. CPSM's guidance is being increasingly sought by those administering the health care system and physicians who are both experiencing challenges.

STAFF MATTERS

CPSM is in the process of recruiting a new medical consultant to work in the Quality Improvement Program. CPSM has also transferred Jason Martin and Alison Wiebe from other Departments to work in the Quality Improvement Program.

MEETINGS WITH GOVERNMENT OFFICIALS

A meeting with the Deputy Minister took place on August 15, 2022, at her request. Council will be advised at the meeting about its contents.

MEETINGS ATTENDED - OTHER ORGANIZATIONS

Manitoba Licensing Program for International Medical Graduates Orientation presentation on CPSM – June 23, 2022

Extended Practice Pharmacy Advisory Committee – June 24, 2022

PGME Executive Committee – July 12, 2022, September 13, 2022

Federation of Medical Regulatory Authorities of Canada (FMRAC)

- Educational Conference June 11-12, 2022, Topic was "Eradicating Indigenous-specific and other forms of Racism and Discrimination Creating a safe Regulatory Environment for Patients"
- AGM - June 10, 2022

Presidential Advisory Committee – Search for Dean, Rady Faculty of Health Sciences & Dean, Max Rady College of Medicine – May 31, June 3, 14, 27, 2022

Northern Manitoba Nursing Station staffing issues – August 15, 2022

Class of 2024 Welcome to Clerkship – August 22, 2022

Inauguration of Class of 2026 White Coat Cloaking Ceremony – August 24, 2022

Federal Government Final Report on MAiD/Mental Health Meeting – August 25, 2022

PGME Executive Committee – September 13, 2022

Medical Clinical Leadership Council Meeting – September 15, 2022

MEDIA

CBC, CTV, and the Winnipeg Free Press covered the Inquiry Panel decision on Dr. Shamoon Hasham Din and the censure of Dr, Wilhelmus Petrus Grobler.

CPSM's complaints, investigations, and disciplinary processes were the target of 10 Winnipeg Free Press articles between June and August. CPSM has been cooperative and in the interest of transparency to the public, responded to over 60 questions.

COMMUNICATIONS

A public awareness campaign about CPSM's role to protect the public is under consideration.

The Annual Report was finalized and submitted to government.

FINANCE

The Finance, Audit & Risk Management Committee meets three times a year. The first meeting of the year is scheduled in November after CPSM has reached the first six months of annual operations. As such, there is nothing to report for the September 29, 2022 Council Meeting.

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

INFORMATION TECHNOLOGY

Members of the CPSM IT team and the COO met with 3 MRA's that currently utilize the iMIS system. The 4 Colleges reviewed their current state and potential future options. The 4 colleges have committed to continue sharing information on this topic on a go forward basis.

CPSM IT continues to work to improve cybersecurity and have implemented additional safeguards in the last few months and have.

The IT team is currently gearing up to support the Registration Department for the upcoming November registration renewals.

QUALITY DEPARTMENT

Physician Health Program

- As of June 1, 2022, there were 18 new referrals to PHP, bringing the program total up to 30 for this fiscal year.
- PHP has implemented a new contact level ranking system, tagging PHP referrals as Low, Moderate or High:
    - Of the 18 referrals 7 are ranked as low level, 4 are ranked as moderate level and 1 is ranked as high.
    - Low level – communication with PHP Coordinator, no impairment identified, file closed without official involvement with Assistant Registrar. Assistant Registrar may advise before closing.
    - Moderate Level – multiple communications with registrant and/or meeting required with Assistant Registrar to determine impairment. May require consent and caregiver reports required to close file.
    - High level – CPSM legal required and/or meeting(s) with Assistant Registrar and Director of PHP required to determine next steps
- Aside from PHP "other" category, the top illnesses being reported are mental health related.
- Quarterly meetings continue to move forward between PHP and Doctors Manitoba. This relationship continues to grow with both organizations supporting and encouraging our registrants to connect with the other as needed – in the interest of protecting patient safety and keeping doctors healthy.

MANQAP

- Diagnostic Facilities:
    - Work continues to reduce the backlog of inspection resulting from COVID-19 pandemic restrictions.
    - 3 new diagnostic imaging sites have been accredited to open.

- Non-Hospital Medical Surgical Facilities
    - The CPSM NHMSF Standards have been approved for use. These standards are adapted from CPSA's NHSF.
    - Accreditation inspections have begun using the New NHMSF Standards.
    - The new Adverse Patient Outcome (APO) process has been implemented. Work continues to refine the process
    - Work continues with the NHMSFs to develop a standardized list of procedures and names
- Work has begun with CPSM IT to move MANQAP data (diagnostic facilities and NHMSF) to the CPSM Portal.

Quality Improvement Program

- Program operations continue at a normal pace.
- Auditor Training Workshop took place May 2022. Another one will be planned for November 2022. Attendees will be accepted based on CPSM needs/gaps – across all audit programs.
- Continued expansion into different specialty areas year by year.
- Central Standards Committee now oversees the QI Program, the process is going smoothly.
- QI staffing doubling to 2 full time administrative staff and 2 0.6 EFT medical consultants to enable meeting the timeline as outlined in the RHPA.

Standards Audits and Monitoring

- Total qualifying audits scheduled for 2022 is 73, which includes:
    - audits carried over from 2021.
    - 14 in the 73 years of age category.
    - 25 in the 72 years of age category
    - 11 repeat age triggered
    - 12 referred audits
- The Age Triggered Audits Program is currently scheduling audits of 73-year-old physicians. 72-year-old physicians will begin later this fall and carried out through the winter.
- A new process for auditing physicians that indicate that they are working as consultants only for organizations such as WCB, MPI and Insurance Companies is currently in development.
- A more defined CPD process is also in development and should come into effect following the 2022-2023 Certificate of Practice renewals.

Prescribing Practices Program

- SUAP Grant
    - 2 Opioid Agonist Therapy (OAT) workshop held (May & June 2022).
    - Responded to 37 OAT Mentoring requests (involving 119 contacts by email/phone) from professionals seeking advice/support (Registrants, Pharmacists, Nurses, Allied Health). 29 (78%) required simple intervention, 8 (22%) intermediate intervention.
    - OAT Recommended Practice Manual
        - Consolidating new Suboxone Manual writing with revision of previous Methadone Manual into one manual.

        - 3 new chapters completed (14 total chapters posted thus far). 5 chapters in active draft stage.
        - Completed 5 OAT Quality Improvement Audits and 1 site visit. Planning to complete OAT audits for 5 physicians (1-2 per month) in fall 2022.
- OAT Program
    - Issued 5 OAT (Methadone & Suboxone) Prescribing Approvals since May (13 new OAT approvals total thus far in 2022).
    - 16 new applicants (in training process) since May.
- Pain & Palliative Care (P&P) Methadone
    - Issued 2 Methadone (for palliative care analgesia) Prescribing Approvals since May.
    - P&P Prescribing Approvals expired June 1, 2022 (every 3 years).
        - 69 Registrants sent Renewal Questionnaire via Member Portal (93% Response Rate).
        - 54 Renewed. 10 opted not to renew. 5 did not respond. (Involving 216 email/phone/mail contacts.)
- General Prescribing Advice
    - 36 cases reviewed and general or case-specific prescribing advice provided professionals/callers seeking advice/support.
        - 18 (50%) were Registrants queries, 15 (42%) Pharmacist queries, 3 (8%) other sources.
        - 27 (75%) required simple intervention, 4 (11%) intermediate, 5 (14%) complex.
- Completed 1:1 Educational Mentorship Sessions with 4 Registrants. These sessions are either in response to a physician requesting support from CPSM or PPP addressing gaps identified in patient care.
- 1 Registrar Referral opened then closed (as physician was no longer practicing).
- CME Death Review Program: Completed review of Q1 and Q2 2021 cases as able (due to delays in the Medical Examiner's office finalizing reports).
    - Total of 50 CME review letters sent to Registrants from May-August 2022, few cases still in progress.
        - Out of the above, 12 initial CME Death Review letters included a request for additional, detailed case information from prescriber(s) involved.
        - Thus far, we have followed-up and responded to 8 letters received back and, in turn, provided extensive education whilst concluding our review.
    - Secondary review process (for physicians with ≥3 concerning cases in the previous 36-month period) planned for 10 Registrants in 2022-2023.
- Ketamine Project
    - Other Canadian Colleges shared concerns re: ketamine prescribing in their jurisdictions, including IV ketamine. In response, PPP reviewed DPIN data to determine if similar concerns exist in MB, potentially requiring regulatory guidance. Also met with Dr. Murray Enns to gain local expertise re: off-label use of ketamine for treatment resistant depression.
    - PPP assisted Executive to create a position statement re: IV use of ketamine in Manitoba.
    - PPP assisted MANQAP by providing information re: ketamine to relay to the PRC.

  - Based on further data analysis of ketamine prescribing in MB, PPP will survey 60 registrants re: case-specific ketamine prescribing to determine if further regulatory guidance is needed.
- Contributed 1 article to CPSM eNews (re: M3P prescription pad supply changes).
- Participating in Prescribing Rules Review Committee (PRWG) for review of M3P program. Attended 3 meetings (including 1 smaller working group) and reviewed documents. Will bring working group recommendations back to PRWG on September 15, 2022. Will assist in rollout of any changes. The latter will likely require substantial PPP staff hours to ensure successful implementation.

COMPLAINTS & INVESTIGATIONS DEPARTMENT

The Complaints and Investigation Department continues to be extremely busy addressing complaints from the public. Long resolution times are acknowledged, and progress is being made to address the backlog.

In terms of recent media attention, the Department has provided what information it could to respond to questions from the media about its processes. It is aware that media coverage has focused on the handling of complaints about a specific physician who has been charged with criminal offences which have not yet been proven. It is public record that the trial is scheduled for next spring.

Council will be aware that the main criticism of the articles was CPSM's approach to an investigation in the context of the concurrent police investigation and/or court proceedings. The media has portrayed the decision to hold open investigations relating to the same subject matter as the criminal proceedings as a set policy which the media equates to an abdication of our responsibilities. This characterization is both inaccurate and misleading. To be clear, we have processes in place which include input from legal counsel and assessing whether to defer our investigation pending the outcome of the criminal proceedings.

There are many considerations, and fortunately, this is a rare event. An important consideration is the risk of our proceedings interfering with the criminal proceedings. A balancing of the various considerations usually results in CPSM holding our investigative processes, such as interviewing witnesses, in abeyance once we are satisfied there are adequate public protections in place. We then carefully monitor the criminal proceedings.

Once any court proceedings are finished, the Executive Committee has the ability to take away a physician's certificate of practice based on a conviction. We can also pursue concerns about the conduct when no criminal conviction results. This recognizes that although criminal conduct was not proven, there may still be allegations of professional misconduct to be addressed.

It is important to understand that whenever any serious allegations such as this are received, our process involves taking swift action to ensure conditions are in place to address the risk to the public while our investigation ensues.

In this case, it is public knowledge that:

1. CPSM initially took steps to protect the public through conditions on the physician's practice requiring an attendant for certain examinations, which conditions were made pubic through signage requirements and by posting information on the physician's CPSM profile on our website.
2. Later, when criminal charges were laid, CPSM ensured the physician was removed from practice before it officially suspended its investigation.

Council will also be aware a review of CPSM's approach to allegations of boundary violations resulted in Standard of Practice that became effective March 31, 2021.

REGISTRATION DEPARTMENT

Fairness Registration Practices Office

The *Fair Registration Practices in Regulated Professions Act* came into effect December 2021.

The amendments to the Act include new requirements to:

- Ensure necessary assessment criteria
- Comply with labour mobility obligations in domestic trade agreements
- Notify FRPO regarding changes to assessment and registration practice
- Take reasonable measures collaborating with educators and employers for remedial opportunities

The FRPO are scheduling reviews, in 3 Blocks, with all regulatory bodies that fall under this Act. They are predicting each Block will take 3 months. CPSM is scheduled for the first Block to commence September 2022.

After an initial meeting with the FRPO, they will provide a draft report which will include any recommendations for improvement of our processes. A closeout meeting will be to discuss action plan commitments by CPSM.

LEGAL

A Human Rights Complaint was filed against CPSM by a patient alleging the Standard of Practice for Prescribing Benzodiazepines discriminates against their access to these drugs. CPSM participated in mediation, which remained unresolved. CPSM has been advised the complaint has been terminated.

COLLABORATIVE CARE STANDARD OF PRACTICE

Concerned that the requirements in a Standard was not being followed, the Central Standards Committee sought registrant feedback through a survey:

> Obligations of Consultant Registrant
> 3.1. A consultant registrant or registrant's service must respond to the patient and registrant verbally or in writing to a request by a registrant for a non-urgent consultation within 30 days of receipt of the request and must notify the patient and the referring registrant of the anticipated appointment date.

To better understand why this occurs, information was sought from those working in a consulting capacity and are experiencing barriers in practice (internal or external) that may prevent them from meeting this requirement. Diagnostic imaging requests are considered requests for consultation.

The results of the survey were discussed at the Executive Committee. Constraints in the healthcare system limits administrative resources thereby limiting the ability of physicians to comply with the 30-day response. It was considered whether the response could simply be an acknowledgment of receipt and approximate estimate of appointment date. There appears to be widespread non-compliance with this provision of the Standard. Dr. Ziomek will meet with leaders in the healthcare system to determine if system improvements can be made. Dr. Ziomek will report back to the Executive Committee following meetings.