Special Council Meeting

Monday | May 26, 2025 | 4:00pm

AGENDA

Virtually - Join Zoom Meeting
https://us02web.zoom.us/j/86241471371?pwd=kADrfbqfVxE6vyk9a31fUfmbauzV5U.1
Meeting ID: 862 4147 1371
Passcode: 000883

Time		Item		Action		Page #
5 min	4:00 pm	1.	Opening Remarks and Land Acknowledgment		Dr. Shenouda	
0 min	4:05 pm	2.	Agenda – Approval		Dr. Shenouda	
0 min	4:05 pm	3.	Call for Conflict of Interest		Dr. Shenouda	2
55 min	5:00 pm	4.	Regulation Consultation • Appendix 4.1 Regulatory Amendments (page 12-13) • Appendix 4.2 Consultation Results (page 14-83) • Appendix 4.3 Clinical Assistant Feedback (page 84-101)	For Approval	Dr. Shenouda	3
1 hours			Estimated time of session			

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.

SPECIAL COUNCIL MEETING
MAY 26, 2025
NOTICE OF MOTION FOR APPROVAL

SUBJECT: **CPSM General Regulation Amendments**

BACKGROUND:

CPSM consulted on the following 3 potential amendments to the *CPSM General Regulation 163/2018*:

1. **American Board-Certified Physicians**

   "The first proposed change will allow all physicians from the United States to apply directly for full (practicing) class if they meet the following requirements:
   - have successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education,
   - hold certification from a Member Board of the American Board of Medical Specialists (ABMS), and
   - have an independent or full licence to practice with a U.S. state medical board.

   Currently, these individuals must first apply for provisional registration, which places limitations on their ability to practice medicine (such as requiring supervisors, assessments, and practice location restrictions). These restrictions are costly and time-consuming. They place a significant disincentive on qualified physicians applying to practice medicine in Manitoba."

2. **Reducing barriers for Provisional Registration of Family Registrants**

   "Provisional registration is granted to physicians who meet some but not all requirements for full practicing registration. A registrant who is provisionally registered will be entitled to practice medicine with certain limits and conditions at a geographic location approved by the Minister of Health. Conditions include the need for supervision and practice audits. A provisional registrant will have five years to attain all the requirements for full registration.

   The *CPSM General Regulation* lists the requirements an individual must have to apply for provisional registration. There are multiple pathways for registration in the provisional (family practice-limited) class, one of which is that the applicant has completed at least one year of post-graduate clinical training in family medicine and has **"at least three**

years of practice experience in family medicine in the preceding five-year period." Candidates who follow this route to provisional registration will typically require a Workplace-Based Assessment (i.e., a Practice Readiness Assessment through the Manitoba Faculty's International Medical Graduate (IMG) Program).

The prerequisite of having at least three years of practice in family medicine in the preceding five-year period to apply for provisional registration was separately reviewed by the Manitoba Faculty and CPSM's Board of Assessors (which was established to consider complex registration applications). They recommended the prerequisite be amended to **"*a total of at least 960 hours of direct patient clinical practice experience in family medicine in the preceding 36 months.*"** This is approximately equivalent to six (6) months of practice in the past three years.

CPSM and the Manitoba Faculty believe that these changes will increase the number of individuals who meet the registration requirement and Practice Ready Assessment eligibility, and at the same time improve the likelihood that they will successfully complete the requirements of provisional registration."

3. **Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.**

"Clinical Assistants are CPSM registrants who have a critical role in the delivery of health care in Manitoba. Many have a medical degree from a nationally approved faculty of medicine in another jurisdiction or, in some cases, Canada. However, those with medical degrees are not entitled to use the title "Dr." or "Doctor" in the practice of medicine, even though they were previously able to use the title while in residency in Canada, or as a practicing physician in another country.

Other health care professionals who may use the "*Dr.*" or "*doctor*" title in Manitoba, in conjunction with identifying their profession include optometrists, dentists, chiropractors, and naturopaths."

The proposed regulatory amendments are attached as ***Appendix 4.1 Regulatory Amendments***.

111 responses were received. 97 were from registrants, 9 were from members of the public, and 5 were from stakeholders. Some respondents addressed all three proposed amendments while others addressed one or two amendments. All anonymized responses are attached as ***Appendix 4.2 Consultation Results***. To aid in reviewing the responses, the numbers 1, 2, or 3 were added to the response to indicate which of the

above amendments the comments were addressing. The submissions related to allowing Clinical Assistants to use the title "Doctor" were the most contentious. To aid it reviewing of the comments, the responses were organized and are attached as ***Appendix 4.3 Clinical Assistant Feedback*** into the following themes:

- Patient safety, confusion, misleading
- Credentials in question
- Workplace issue (dignity and respect), not title issue
- No problem/neutral about the proposed amendment. Agrees with CPSM's terms and rationale
- Unclear feedback
- HARD NO. Greatly opposes proposed amendment

Councillors should review all the responses; however, the following is a high-level summary.

American Board-Certified Physicians

54 responses were received. 38 expressed support for the amendment and 8 expressed opposition. Most of those who expressed opposition were not concerned with permitting the licensure of American Board-Certified Physicians but rather they felt other internationally trained physicians were being discriminated against. A few who expressed support also noted that not every American Board-Certified Physician will automatically have equivalent training to Canadian licensed physicians and that it is important to CPSM to ensure proper monitoring. All 7 members of the public expressed support for the proposed amendment.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MAY 26, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

The proposed amendment to ***subclause 3.8(b)(i.2)*** of *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is approved.

Alternatively:

The proposed amendment to ***subclause 3.8(b)(i.2)*** to *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is denied.

Reducing barriers for Provisional Registration of Family Registrants

31 responses were received. 16 expressed support for the amendment and 7 expressed opposition. The remainder of the comments cannot easily be characterized as support or opposition but rather observations. Those who expressed opposition were concerned that reducing the qualifications would reduce the quality of applicants.

The Manitoba Faculty recommended, in consultation, that the following be added at the end of the proposed amendment - "for recency of practice; and a total of 2 years of independent practice since post grad training". They state ensuring a history of independent practice is predictive of a successful outcome.

The amendment would read:

"a total of at least 960 hours of direct patient clinical practice experience in family medicine in the preceding 36 months, for recency of practice; and a total of 2 years of independent practice since post graduate training."

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MAY 26, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

The proposed amendment to ***subclause 3.19(1)(b)*** of *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is approved.

Alternatively:

The proposed amendment to ***subclause 3.19(1)(b)*** of *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is approved with the addition of ", for recency of practice; and a total of 2 years of independent practice since post graduate training."

Alternatively:

The proposed amendment to ***subclause 3.19(1)(b)*** to *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is denied.

Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.89 responses were received. 29 expressed support for the amendment, 58 expressed opposition, and 2 did not express support or opposition.

Most of the responses in favour of the amendment were short and did not provide extensive explanation for their position. One respondent did state:

"I would be delighted to see this change. In Neonatology we have two CAs and to be honest they are both among our top performers. I have always found it distressing that they are unable to refer to themselves as doctors and specifically introduce themselves as such when they are so talented. With the way our CAs function and knowing their background would allow them to be physicians in their home country I think it is a small but important gesture to let them know we value them."

And another stated:

"The use of the title "Dr." is an acknowledgment of academic and professional achievement, and many Clinical Assistants possess degrees such as MBBS, MD or equivalent. The ability to use a title values their expertise and contributions to healthcare in Canada.

As long as the title is used alongside the full professional designation e.g., "Dr. Smith (Clinical Assistant.) there is minimal risk of public confusion. It promotes transparency and respect for academic accomplishment. This enhances patient trust and interdisciplinary collaboration.

Moreover, many healthcare systems around the world already recognize and support the use of "Dr." by non-physician doctorate holders, provided appropriate context is maintained. Aligning with this standard reflects a progressive and inclusive approach.

I fully support this proposal and believe it upholds both professional integrity and respect for individual qualifications."

The rationale for those who oppose the amendment can be divided into two arguments.

1. Clinical Assistants do not have the same credentials as licensed physicians in Manitoba and should therefore not be permitted to also call themselves "doctor" as this will diminish the respect for the title "doctor". Some examples of this position are:

   "Why did I go to school for 12 years to become an MD FRCP??? Not sure what is wrong with their title of physician assistants [sic]?"

"There is a big distinction between MDs (Doctors) (who spend many more years of intense training) and clinical assistants. Currently patients associate the term Dr with that degree of training and expertise. To provide that designation to clinical assistants would be demeaning for all true MDs. I think this would be degrading for our profession. The image of physicians has eroded over time and this would enhance this erosion."

2. Clinical Assistants using the title "doctor" will confuse the public who will mistakenly believe they are receiving medical care from a licensed physician. This was the most commonly expressed concern.

Examples of some comments are:

"Using the title "Dr." or "Doctor", regarding of putting (Clinical Assistant) in a note or document, makes them virtually indifferentiable from physicians to an average patient. Clinical Assistants, as we know, are physician-extenders. To a patient, they won't be able to understand the difference between a C.A and a Physician if the C.A is referring to themselves as doctor. For one, many physicians do not see patients seen by their physician-extenders and so any interaction that someone has with a clinical assistant referring to themselves as "Dr." or "Doctor" can be very easily misconstrued by a patient as having been an interaction with the physician they are meant to see. This has the potential to engender mistrust and confusion in patients, which hurts the profession and undermines the title of "Dr."/"Doctor". Additionally, it is a common concern from patients that they will see a physician-extender, not see the physician and then this can incite a flurry of negative emotions ranging from anger, worry, anxiety and disappointment. Having a Clinical Assistant refer to themselves as "Dr." or "Doctor", yielding confusion for patients, will stand to amplify these negative emotions in many clinical interactions."

"I have read the proposed changes for allowing clinical assistants to use the "Dr" designation. At present I do not think the general patient population even knows what a clinical assistant does and then to add the title would cause further confusion about provider roles."

"While I appreciate and value the contributions of Clinical Assistants (CAs), I have reservations about permitting the use of the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A."

"The public often associates the title "Dr." with licensed physicians, and may not fully grasp the significance of accompanying designations. This could create confusion about the scope and authority of Clinical Assistants."

"As a younger, female, BIPOC physician, I have personally experienced situations where patients question my credentials or authority based on preconceived notions of what a physician "should" look like. Introducing another provider category with the title "Dr." may further complicate public understanding, potentially exacerbating these issues and requiring additional efforts to educate the public on provider roles."

A significant portion of the responses indicate concern regarding the public being confused about the status of a Clinical Assistant being referred to as a "doctor". What is also evident from the comments is there is significant confusion among physicians as to the role and qualifications of Clinical Assistants.

The table below compares the qualifications of various registrants, and their ability to use the title "doctor". For clarity, Clinical Assistants referred to below are only those who have the prerequisite Medical Degree, Clinical Assistants who do not have the prerequisite Medical Degree will not be entitled to use the title "doctor".

	Full (Practising)	**Provisional – Family**	**Provisional – Specialty**	**Residents**	**Retired**	**Clinical Assistant**
Can use "doctor" title	✓	✓	✓	✓ (Must make the patient aware of their stage in postgraduate program	✓ (Must indicate ret.)	✘
Medical Degree	✓	✓	✓	✓	✓	✓
Post-Graduate Training	Has RCPSC/CFPC certification, CMQ, MPAP, SEAP aff.	Incomplete or non-CFPC Satisfactory PGT in FM and, in some cases, independent practice experience.	Incomplete or non-RCPSC Satisfactory training and qualifications to practice independently in specialty field.	Enrolled in PGME in Manitoba	N/A (Past licensure required.)	N/A (May have PGT, but not a requirement.)
Assessment or Exams Required	N/A	May require PRA, unless exempt	May require PRA, unless exempt	Admission to PGME program	N/A	LMCC, NAC-OSCE, CAA, or RC fellowship.
Supervision/ Conditions	N/A	Yes – Supervision required	Yes – Supervision required	Yes – Under PGME supervision	No patient care permitted/not licensed.	Yes – Limited scope, supervision mandatory
Eligible for Independent Practice	✓	✓	✓	✘	✘	✘

Some comments were particularly insightful:

"I work with CAs and have many who have incredible skill sets, but occasionally some who really should not have Doctor as their title, and this could do harm.

It raises the question what does Doctor even mean? Certainly you need to do public education if you pursue this course."

Another physician stated:

"It seems unfair not to allow someone to use the title Dr. if they actually have an MD or equivalent from a legitimate training program somewhere. The risk is the potential for the public to be misinformed as to whom they are seeing. If we were to allow this, then there would be have to be significant protections against that.

1. *It would have to be strictly enforced that they only be able to use Dr. in conjunction with "clinical assistant" and never on its own in any medical context*
2. *We would need some process/criteria to determine whether their degree is in fact equivalent to an MD.*
3. *Assuming such a verification is in place, a clear and transparent way of informing the individual of the result of that verification, and recording in their registration somehow whether are or are not allowed to use Dr."*

Doctors Manitoba stated:

"Some members also expressed concern about confusion by patents and their families respecting the role of Clinical Assistants, the nature of their education and training, and their scope of practice.

At the same time, some members noted that medical residents are already able to use the title "Doctor".

We agree that there may be some confusion in practice settings, as patients and their families may not make the distinction between physicians and Clinical Assistants. At the same time, patients may be frustrated by some limitations on the practice of Clinical Assistants. We believe this requires efforts by the CPSM to educate the public.

We recommend that the CPSM prepare easily referenced and easily understood materials to allow the public to understand the training and scope of practice of Clinical Assistants, and the fact that they may be prepared to commit to further training in Manitoba to become physicians.

We believe this proposed change is complex. While we appreciate the CPSM's view of the recruitment and retention benefits, we think more work needs to be done to prepare the public.

Accordingly, we respectfully ask that this proposed change be deferred to allow for more discussions and dialogue, to prepare for a communications and education plan by CPSM for members and the public generally. This will ensure a broader understanding of the respective roles of physicians, residents, Physician Assistants, and Clinical Assistants, including why only some are able to use the title "Doctor" in clinical settings. A plan to promote and explain the pathway of Clinical Assistants to fully licenced physicians would aid in the "social marketing" to our members and the public."

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MAY 26, 2025, DR. CHARLES PENNER, PRESIDENT-ELECT, WILL MOVE THAT:

The proposed amendment to add ***subsections 6.9(3) and (4)*** to *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is approved.

Alternatively:

The proposed amendment to add ***subsections 6.9(3) and (4)*** to *The College of Physicians and Surgeons of Manitoba General Regulation 136/2018* is denied.

Alternatively:

The proposed amendment to add ***subsections 6.9(3) and (4)*** to *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is approved with a coming into force date of June 1, 2026 to provide CPSM sufficient time to educate registrants and the public regarding the amendment.

Alternatively:

The proposed amendment to add ***subsections 6.9(3) and (4)*** to *The College of Physicians and Surgeons of Manitoba General Regulation 163/2018* is tabled until the June 2026 meeting of Council to provide CPSM sufficient time to educate registrants and the public regarding the amendment.

Proposed amendments to *College of Physicians and Surgeons of Manitoba General Regulation*
(The Regulated Health Professions Act)
Consultation draft

Projet de modification du *Règlement général sur l'Ordre des médecins et chirurgiens du Manitoba*
(Loi sur les professions de la santé réglementées)
Ébauche pour consultation

Manitoba Regulation 163/2018 amended

1 The *College of Physicians and Surgeons of Manitoba General Regulation*, Manitoba Regulation 163/2018, is amended by this regulation.

Modification du *R.M.* 163/2018

1 Le présent règlement modifie le *Règlement général sur l'Ordre des médecins et chirurgiens du Manitoba*, *R.M.* 163/2018.

2 The following is added after subclause 3.8(b)(i.1):

(i.2) the applicant holds

(A) a licence issued by the medical board of a state of the United States to engage independently in the practice of medicine, and

(B) Member Board certification and has satisfactorily completed a post-graduate training program accredited by the Accreditation Council for Graduate Medical Education (USA),

2 Il est ajouté, après le sous-alinéa 3.8b)(i.1), ce qui suit :

(i.2) elle répond aux critères suivants :

(A) elle est titulaire d'un permis délivré par une commission médicale d'un État des États-Unis et lui permettant d'exercer la médecine seule,

(B) elle est titulaire d'un certificat d'un conseil membre et a suivi de façon satisfaisante un programme d'études supérieures agréé par l'Accreditation Council for Graduate Medical Education (É.-U.),

3 Subclause 3.19(1)(b)(v) is amended by striking out "three years practice experience in family medicine in the preceding five-year period" **and substituting** "960 hours of practice experience in family medicine in the preceding 36 months"**.**

3 Le sous-alinéa 3.19(1)b)(v) est modifié par substitution, à « trois ans au cours des cinq années précédentes »**, de** « 960 heures au cours des 36 mois précédents »**.**

4 The following is added after subsection 6.9(2):

6.9(3) Despite subsection 6.3(3), a member referred to in subsection (1) is permitted to use the title "doctor (clinical assistant)" and the abbreviation "Dr. (Cl. A.)" or any variation of them or equivalent in another language if the member holds

(a) a medical degree granted from a nationally approved faculty of medicine; or

(b) a Doctor of Osteopathic Medicine degree from a school in the United States accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation.

6.9(4) A person — other than a member referred to in subsection (3) — must not use the title or abbreviation listed in subsection (3) or any variation of them or the equivalent in another language alone or in combination with other words in a manner that states or implies that the person is a clinical assistant with a degree in medicine or osteopathic medicine.

4 Il est ajouté, après le paragraphe 6.9(2), ce qui suit :

6.9(3) Par dérogation au paragraphe 6.3(3), les membres visés au paragraphe (1) sont autorisés à utiliser le titre de « docteur (assistant médical) » et son abréviation « D^{r} (ass. méd.) », une variation de ces derniers ou encore un équivalent dans une autre langue s'ils sont titulaires :

a) soit d'un diplôme de médecine décerné par une faculté de médecine agréée à l'échelle nationale;

b) soit d'un diplôme de docteur en médecine ostéopathique d'une école des États-Unis agréée par l'American Osteopathic Association Commission on Osteopathic College Accreditation.

6.9(4) Les membres visés au paragraphe (3) sont autorisés à titre exclusif à utiliser le titre et l'abréviation prévus au paragraphe (3), ou une variation de ces derniers ou encore un équivalent dans une autre langue, seuls ou avec d'autres termes de manière à indiquer ou à donner lieu de croire qu'ils sont des assistants médicaux titulaires d'un diplôme de médecine ou de médecine ostéopathique.

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Public Consultation: Three regulation amendments: Feedback

Color code
1. Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants;
2. Reducing barriers for Provisional Registration of Family Registrants;
3. Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.

Registrant Feedback

3 Why did i go to school for 12 years to become an MD FRCP ??? Not sure what is wrong with their title of physician assistants?

1 I am responding primarily to the proposal regarding U.S. licensed and trained physicians. I am one of those and have a particular interest in this issue.

I arrived in 1975 with certification in Internal Medicine by the ABIM. In 1978 was certified in Cardiovascular Diseases. My license to practice medicine in Manitoba was, I believe, only granted under a clause allowing the U. of Man. to request licensure to faculty members with that status remaining only as long as such physicians remained within the U. of Man. umbrella. If such a policy persists it should be reviewed. A specialist should be a specialist regardless of their employment status; and there should be minimal barriers to obtaining a general license.

It also appeared that such licensure was restricted to Manitoba and was not, per se, Canadian licensure, either as an internist or as a cardiologist.

As barriers to licensure are considered I would appreciate that these issues be included in your discussions.

Be glad to discuss.

1 Questions to consider:
Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba? **Yes**
Do these changes negatively impact patient safety? **Not at all.**
Or are the current regulatory requirements appropriate? **No**
As a US board certified neurologist in General Neurology and Vascular Neurology, having worked in HSC for almost 10 years now, I faced this exact same issue; get ASSESSED by two Canadian certified physicians and a nurse to see if you are qualified for an independent license to practice medicine safely. And obviously if you don't agree to this assessment that could cost up to $40K, then you can not practice.

And I will not be practicing medicine in MB after a few months due to this reason.
3 I am very much against PA or CA using title of doctor. If they have a masters they are not doctors by any standards. If they were doctors in another country they have to have the certification that says they are capable of being doctors in Canada. I have research assistants who have spent many years in my clinic and understand gi medicine very well. But they are not doctors and the public should not feel they can rely on them to the same extent as doctors
3 I wanted to provide some feedback to the proposed Regulation Amendments. In particular: Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." I strongly oppose this change as it will be confusing to patients and other providers as to the qualifications of the individual involved. Patients may assume that the clinical assistant is ultimately responsible for their care and has the same qualifications as a physician. Likewise, other providers including physicians, nurses and allied health may make the same mistake. While clinical assistants make a valuable contribution to patient care, they are not physicians. Allowing them to use the title Dr will ultimately blur that line in the eyes of patients.

I don't know how many people respond with no negative comments but for what it's worth. I approve.
3 I would very much oppose this and quite frankly am very surprised that it is even being considered. There is a big distinction between MDs (Doctors) (who spend many more years of intense training) and clinical assistants. Currently patients associate the term Dr with that degree of training and expertise. To provide that designation to clinical assistants would be demeaning for all true MDs. I think this would be degrading for our profession. The image of physicians has eroded over time and this would enhance this erosion. More importantly, it would really confuse patients. This gives the illusion that there is little difference between family MDs and clinical assistants when in reality there is a massive difference including a more arduous pathway to get into an MD program (MCAT (which has to be studied for and frequently written multiple times), MMI interview, Caspar, university grades) and then a minimum of 6 years of training with arduous call schedules etc vs a relatively superficial 2 year training program. (I teach in this program) It really would be unfair and dangerous to the public to have them think that these roles are interchangable. The term doctor should be reserved for those who have truly earned it by completing an MD and the additional postgraduate training that is required, I respectfully plead with you to not carry this forward. It would be very harmful for our profession as a whole **Follow-up email sent:**

In reading this over more carefully, I realize that I was thinking that this was for 'physician assistants' not 'clinical assistants' who have already obtained a medical degree somewhere else.

I still think that it is confusing for the public to know what the qualifications are and what authority the clinical assistants really have. I believe there are processes in place for for them to get licensed in Manitoba and once this occurs, then it would be reasonable to refer to them as doctors.

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1 2 3

1- I completely agree to this change and would welcome it especially in the existing scenario, when we are likely to get many American trained physicians.

2- I think 6 months is too short and would recommend one year.

3- I completely agree to this change.

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1 2 3

Thank you for public consult for the proposed changes.

Please make the voting for these changes easier by putting it on a website with a box of agree or disagree that we just put a yes or no?

Regarding the proposed changes:

1- NO, I do not agree with reducing the requirements for the American licensed doctors. Instead look into reducing the interprovincial barriers for the CANADIAN GRADUATE DOCTORS.

2- I support any reduction in interprovincial barriers whether for family doctors or other specialists.

3- NO, I do not agree with putting the hard earned title of a doctor in canada to anyone who is nit fully licences to work as a physician in Canada...

We spent years and years to earn this title and giving it away that easy to any non Canadian licences physician meeting the Canadian standard is disheartening.

3

My name is ***** and I am Physician working in Winnipeg.

I strongly oppose the following:

"3. Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A.”"

There are a number of reasons why Clinical Assistants should not be calling themselves doctors within our system:
- Using the title "Dr." or "Doctor", regarding of putting (Clinical Assistant) in a note or document, makes them virtually indifferentiable from physicians to an average patient. Clinical Assistants, as we know, are physician-extenders. To a patient, they won't be able to understand the difference between a C.A and a Physician if the C.A is referring to themselves as doctor. For one, many physicians do not see patients seen by their physician-extenders and so any interaction that someone has with a clinical assistant referring to themselves as "Dr." or "Doctor" can be very easily misconstrued by a patient as having been an interaction with the physician they are

meant to see. This has the potential to engender mistrust and confusion in patients, which hurts the profession and undermines the title of "Dr."/"Doctor". Additionally, it is a common concern from patients that they will see a physician-extender, not see the physician and then this can incite a flurry of negative emotions ranging from anger, worry, anxiety and disappointment. Having a Clinical Assistant refer to themselves as "Dr." or "Doctor", yielding confusion for patients, will stand to amplify these negative emotions in many clinical interactions. In summary, it is my understanding that as a regulated profession we must protect our patients. Adding "Dr." or "Doctor" to a Clinical Assistants title does the exact opposite as this sort of addition has great potential to create confusion and negative emotionality around interactions with Clinical Assistants. This stands to hurt the profession, undermine the title of "Dr."/"Doctor" and engender mistrust in the College and the Physicians who are overseen by the college. I strongly urge against using the title "Dr."/"Doctor" for Clinical Assistants as outlined by the opposed amendment. I would be happy to speak further with anyone if they have questions regarding the information I am sharing or are seeking further thoughts/information from my perspective
3 I would like to respectfully express my concern regarding the use of the title "Dr" by Clinical Assistants (CAs). In my opinion, this practice contributes to significant confusion among patients—particularly those with limited familiarity with the healthcare system. When CAs present themselves using the "Dr" title, patients may reasonably assume that they are seeing the "most responsible physician" for their care. This kind of misperception can unintentionally impact patients' understanding of their care, including who is responsible for key decisions. Clear communication about roles helps preserve trust and supports truly informed consent. Patients deserve to understand who is providing their care and what qualifications that person brings. This misperception can undermine informed consent and the trust that should exist between patients and their healthcare team. Additionally, from a practical standpoint, this ambiguity creates challenges in continuity of care. For instance, patients often present to the clinic stating they've previously seen "Dr. Smith," only for it to be clarified later that "Dr. Smith" was in fact a CA. This confusion makes it more difficult for front staff to track down appropriate documentation such as consultation notes, ultimately hindering patient care. I deeply value the essential contributions that CAs and PAs make to our system. However, titles matter. The distinctions exist for a reason, and clarity in these roles is essential for both patient safety and system function. Thank you for considering this perspective
3 I am opposed to Clinician assistants using Dr. before their name. Recent data coming from the UK shows that patients want clarity regarding who is a physician and who is not. Allowing clinician assistants to use DR will definitely not improve clarity/transparency to patient care.

Also I really believe this question should be asked to patients and not to physicians. Myself as a patient I would also like to know who is a trained physician and who is a clinical assistant. Them using DR does not let patients know the difference.

I am happy to discuss this further if needed
Regards, and thanks for the opportunity to provide feedback

1 I am supportive of all 3 proposed changes.
Most supportive of the change to American board certified physicians and the free trade. I would like to see pressure on the Government to irradicate the labour and immigration market analysis for physicians at this time. We have been waiting 4 months for the governmental process to be completed and it is not yet complete. I am concerned the physician we hired will not end up here due to the length of the process. Breading down these barriers will be very beneficial. Thank you

2 3 **2.** In regards to reducing barriers for Provisional registration of Family Registrants: I disagree with this as family medicine is already a speciality that is often looked down upon by specialists. By removing further barriers, we may encounter more family physicians who do not have adequate training, enforcing specialists to not trust family physicians. In addition, the public may also lose confidence in family doctors as they may not understand that this is a "provisional licence". I believe that we should continue to hold high standards for family medicine, advocating that this is a very important specialty that requires sufficient and adequate training in order to practice.

3. In regards to allowing Clinical assistants to use the title "Doctor": I disagree with this as well. The title "Doctor" should only refer to those who are residents or practicing attending. Adding "Doctor" to clinical assistants would only lead to confusion for the public and patients who may not be familiar with how our medical system functions. In addition, the training of many clinical assistants is very different from our Canadian medical training and some do not have adequate training to practice as "doctors", hence the use of this title should be restricted to those who are residents or attending physicians.

1 2 **1.** American training as far as I have heard is far inferior and less supervised and in my view they should be subjected to atleast 4 months assessment like a he existing IMG program for specialists. NO exceptions unless it is an academic and non clinical position.

2. Removing complete barriers for FP, might lead to many FPs leaving Manitoba rather than coming into Manitoba.

1 I was reviewing your recommendations and I agree with all - US trained foreign physicians should have as many barriers to practice removed, given their training is largely on par with ours in Canada, at AGME accredited institutions.
Further, however, if the “practice assessment” requirement is under review, I wholeheartedly agree with abolishing that. I believe the practice assessment that is required (at least if US trained doctors in my department) is a huge detriment to the recruitment of qualified physicians to Manitoba, being that is isn’t a requirement of other provinces. That this assessment is at the cost to the doctor,

and as I understand it runs at around $20k or more - assuming you are upfront with physicians being recruited to this province that that will be a requirement within three years of their coming here (and the cost associated with it is theirs) - we certainly lose out on this, relative to other provinces. The American trained physicians I've worked with in the scope of Forensic pathology have all been as good (sometimes better) than those trained in Canada exclusively.

I think these changes going forward in general are acceptable.

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1 2 3

I would like to offer the following comments:

1. Full (Practising) Class – U.S.-Trained Physicians

I fully support the proposed amendment to allow American Board-Certified physicians with ACGME-accredited residency training and independent U.S. licensure to apply directly for full registration. This change will make Manitoba more competitive in attracting highly qualified physicians and aligns with practices in other Canadian provinces.

2. Provisional (Family Practice-Limited) Class – Practice Experience Requirement

I support efforts to make the provisional registration pathway more inclusive. However, I respectfully suggest reconsidering the replacement of "3 years of family practice in the last 5 years" with "960 hours in the last 36 months."

Many internationally trained physicians currently residing in Canada (including Manitoba) have already spent over 2 years trying to enter the healthcare system. The original 5-year timeframe better accommodates such candidates, who may have paused practice due to immigration, retraining, or licensing delays. A blended or more flexible approach (e.g., either 960 hours in the past 36 months or 3 years in the past 5 years) may provide broader access while maintaining assessment rigor.

3. Use of "Doctor" Title for Clinical Assistants

I support this amendment. Allowing Clinical Assistants with medical degrees to use "Dr." in combination with their title (e.g., Dr. Smith, Clinical Assistant) offers deserved recognition while still maintaining transparency with patients and colleagues.

In conclusion, these amendments represent a positive step toward a more inclusive and practical regulatory framework. I encourage CPSM to consider adjustments that reflect the realities and timelines that many internationally trained physicians face after arriving in Canada.

3

It seems unfair not to allow someone to use the title Dr. if they actually have an MD or equivalent from a legitimate training program somewhere. The risk is the potential for the public to be misinformed as to whom they are seeing. If we were to allow this, then there would be have to be significant protections against that.

1. It would have to be strictly enforced that they only be able to use Dr. in conjunction with "clinical assistant" and never on its own in any medical context
2. We would need some process/criteria to determine whether their degree is in fact equivalent to an MD.
3. Assuming such a verification is in place, a clear and transparent way of informing the individual of the result of that verification, and recording in their registration somehow whether are or are not allowed to use Dr.

3 This change will NOT improve clarity for patients or families.

If a nurse also happens to have a PhD in Archeology, that nurse does not work as "Dr. Jones, RN, BN, PhD" when providing clinical care. They provide clinical service as "I. Jones - GDRN". They become "Dr. Jones" when giving a lecture on Archeology at a University.

International medical graduates who are working in NON-PHYSICIAN roles should not be introducing themselves as "Doctor". If they feel that this restriction is limiting their dignity, they could request to have their degree credentials listed on a Hospital or Clinic ID badge (John Smith, Clinical Assistant, MBCHB / MBBS / MD / PhD / etc). The decision to list these details could be up to the hospitals.

In the realm of clinical service provision, and in all scenarios where a provider is interacting with consumers of the health system on an individual level, the titles "Dr." and "Doctor" should be reserved for graduates of medical schools who are licensed in Canada as PHYSICIANS.
Anything else is confusing.

1 3 Thank you for soliciting member feedback on the proposed regulation amendments. **1.** I am happy to support the reduction of restrictions that may delay American Board-certified physicians from becoming fully-licensed registrants. I feel as if I do not know enough about Family Registrants to provide an educated opinion on that amendment, and will abstain from commenting.

3.For the third proposed amendment, however, I wish to register my strong objection to allowing physician assistants to call themselves “doctor”. I understand the rationale, but feel that it is inappropriate and very misleading to the public. The fact is that if someone does not meet Canadian and provincial requirements to be a practicing physician, they are simply not a doctor and self-labelling as such will lead patients to believe that they are being cared for by someone who has met the appropriate qualifications. This goes against our mandate to be honest and forthcoming with our patients, always.

The fact that naturopaths and chiropractors can do this now is not a valid argument; I suspect if you asked most physicians if that is appropriate they would tell you that it is not, and it does harm to patients by increasing the legitimacy of individuals marketing what are at best placebo treatments and which are at worst harmful interventions.

Thank you for giving us the opportunity to give feedback. I hope it is taken seriously and that withdrawal of the third proposal is considered.

3 I strongly object to mid levels using the term doctor. They do not need it to protect their dignity, they already have plenty. They do not need it to get respect from their colleagues. Doctor is a title with certain connotations to the community at large. And it is a title that is given to people who have done specific training.

The fact that this is even being debated makes me question whether the College is putting the needs of actual physicians at the forefront.

I would like to know what the actual motive for this is.

The government is already trying to supplant trained MDs with mid levels and this kind of action creates a false sense of equivalence that is dishonest and deleterious to the medical profession.
Reconsider, please

1 2 3 I am writing in response to the email requesting feedback on proposed regulatory changes. The changes to points one and two regarding removing restrictions for American physicians and reducing barriers for provisional registrants sound reasonable and I would be on board with them.
I think that allowing clinical assistants to use the title "Doctor" is inappropriate. Although they may have medical degrees from other countries, the majority of clinical assistants do not, and having them refer to themselves as doctors will contribute to patient confusion and erode the standard of education, practice and responsibility that medical doctors adhere to. The suggestion that because naturopaths and chiropractors also refer to them as doctors, its reasonable to allow clinical assistants to do the same doesn't really make sense either; naturopaths and chiropractors are both professions that cause harm to patients either through their interventions (or lack thereof).

I am firmly opposed to this change.

3 There is already much confusion from patients wondering who is providing them care. Are these people nurses (no standardized uniform) or Aides; NPs, Resident MD trainees, CAs, PAs or attending MDs?
This change will add to the confusion and mistrust for competency of care.

Having ANYONE using "Dr." or "doctor" who is not a full MD independently able to practice with a Medical University Degree is an outrage to those of us who do hold this level of certification and expertise.
It is no easy task to earn an attending physician designate that comes with substantial lifestyle and monetary sacrifice. Further, the MD is an earned degree- how dare this organization allow someone who does not possess this degree use its social title.

The College is constantly spouting the need for standardized quality care, yet it is considering diluting the title that comes with the designation, the responsibility and the workload of "Dr." None of these groups are required to be on call, or find a suitable replacement during holidays or sick time. Most of them do not work holidays or weekends, or nightshifts. These groups do not carry anywhere near the level of moral responsibility for pt care, that are imposed on attending physicians. They do not carry anywhere near the legal responsibility that is demanded of attending physicians. They are not mandated to serve on committees, provide teaching to medical students or residents, make court appearances for medical cases, act as mentors for foreign grads, sit on grievance committees, sit on

hospital boards or provide any administrative duties. They are not responsible for private medical information and its security. Further, they cannot prescribe full complement of medications.

Multiple levels of pseudo-providers using this designate will only create more confusion amongst the population with no appreciable benefit. It seems like the College is trying to purposely deceive the public with this type of branding. There is no possible way that these people will be introduced and known as "Dr X, clinical assistant." It is too onerous. You wouldn't call a Navigator for Air Canada "Captain, first operational nav," or a police cadet "Sergeant, junior officer cadet." These titles are simply erroneous and wrong. Titles are earned honours bestowed by Academic Institutions. They are not to be handed out by a professional regulatory body when the mood strikes.

I reject this proposal in the most vehement of terms. I find it wholly disrespectful and denigrating to all of us who have worked (and continue to work) so hard to achieve this designate and level of expertise.

3

1. Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba?

While the intention to recognize the qualifications of Clinical Assistants (ClAs) is commendable, allowing them to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" does not address a regulatory barrier to independent medical practice. This change offers symbolic recognition but does not facilitate licensure or expand the scope of practice for ClAs in Manitoba.

2. Do these changes negatively impact patient safety?

Yes, the proposed amendment could negatively impact patient safety by causing confusion. In clinical settings, the title "Doctor" is commonly associated with individuals licensed to practice medicine independently. Even when paired with "Clinical Assistant," the use of "Dr." may lead patients to mistakenly believe they are under the care of a fully licensed physician, potentially affecting informed consent and trust.

3. Are the current regulatory requirements appropriate?

Yes, the current regulations appropriately restrict the use of the title "Doctor" to those who are licensed to practice medicine independently in Manitoba. This ensures clarity for patients and maintains the integrity of professional titles within the healthcare system.

Additional Comments:

While recognizing the international qualifications of ClAs is important, it is crucial to maintain clear distinctions in professional titles to prevent public misunderstanding. Alternative methods of acknowledging their credentials, such as detailed introductions or informational materials, could be considered without altering title usage.

1 2 3

1. In agreement that American colleagues with good standing looking to practice in Canada have their practice eligibility streamlined, permitting they pass a formalized observership. In anesthesia at least, many anesthesiologists in the US practice with a VERY different model that involves a huge team that they basically supervise, delegate work to, and ultimately don't really participate in patient care. This is obviously very different than our model here where anesthesiologists

basically function solo with one patient at a time and no additional help (eg. In the US many hospitals have an RT to each room, as well as CRNA's while anesthesiologists "oversee"). I would expect at minimum that their skills are assessed and scrutinized during an observership in a tertiary care centre (HSC) to ensure they are able to function.

2. No. We should not be altering the standard required to practice medicine in Manitoba. If applicants/residents/IMG's are unable to pass and meet the requirements to practice in Manitoba, they should not be allowed to practice. Full stop. It is unfair to patients that it is already EXTREMELY vague and confusing to determine if the "physician" they are seeing is a fully licences FRCPC or family doctor, is working on a provisional license, or is doing a practice ready assessment etc. People should have the confidence to know that if they are seen by a doctor (or someone introduces themselves as one) that they are a fully licensed, passed the royal college exams physician. Anything less is sloppy. If the decision is made to go ahead with this, the absolute minimum I would expect is that obvious, full and apparent advertisement is made within these offices that the practitioner in question only has a provisional license and is not fully fledged. Patients deserve to know. Eg. Signage at the desk, paperwork, door etc saying "Dr. John Smith MD (Provisional License Family Medicine)". If I was going to see a family doctor, I deserve to know if someone im seeing is licensed or not.

3. Absolutely and unequivocally no. Full stop, never acceptable. If the clinical assistants (as mentioned, are physicians from countries whose training is not equivalent to Canadian) want to be designated as doctors in Canada, they must complete a Canadian residency. As with issue #2, it is profoundly unfair to patients to produce this facade that they are being seen by "doctors" who have no authority to be so. There is no such thing as a "Doctor of clinical assisting". The fact that this is even being brought up is ridiculous to be honest. Clinical assistants are clinical assistants.

I oppose removing restrictions for recruiting US physicians. We always find differences in their management of our patients when in USA. They don't follow same guidelines and I don't think they will add to our community.

1. Second, I agree to make it easier to get doctors from other provinces as we all practice same way

2. Lastly, I agree to add title doctors to physicians associates as this will encourage more candidates to enrol in this program.

I am in support of the three regulation amendments as proposed in the CPSM email to members dated April 24, 2025.

I am a physician in Manitoba.

Regarding American Board Certified Physicians: I think that as long as it is assessed that the quality of assessment guarantees an appropriate minimum level of training for Canadian practice then I think that attracting North American trained individuals is a good thing. I would approve the proposal.

Regarding provisional registration: I think that additional paths to Practice Readiness Assessments for those who come from abroad is a good thing. I would approve the proposal. Regarding Clinical Assistants using Dr.: I do not think this is a good idea. Although it is true that other types of professionals use "Doctor" these are all within non-medical environments that clearly delineate that professional as being a "different sort of doctor". Although the guideline here would require that clinical assistants introduce themselves as Dr.XX Clinical Assistant, I am skeptical that this would be routinely done and I think that this will create more confusion in spaces where there are already frequent role confusion for patients. If a clinical assistant sees a patient on the ward and introduces themselves as "Doctor" I believe this will introduce more role confusion, patients understand what a doctor is but may have uncertainty what the additional designation of clinical assistant means. Thanks for collecting this feedback.
3 As a Clinical Assistant in Manitoba, I fully support allowing us to use the title “Dr.” along with our role for example, “Dr. [Last Name] (Clinical Assistant).” Many of us have medical degrees and have worked as physicians in other countries. Being able to use the title “Dr.” would be a sign of respect for our education and experience. It’s something we earned, and it’s already allowed in other provinces like Alberta, Saskatchewan, and BC. Using “Dr.” together with “Clinical Assistant” makes things clear for patients and doesn’t create confusion about our role. It’s a fair way to recognize our contribution to the healthcare system. I would be proud to use the title again and hope this change is approved.
3 I agree to items 1 and 2 but not on item 3. My rational is that calling CA doctors will definitely lead to confusion among the public about MD and CA specially that both could be practicing in the same facility. Optometrists, dentists, chiropractors, and naturopaths all have different parhways the medicine and they are well recognized by public as different professions than MD.
1 3 I think that US or foreign trained physicians holding active current certification should be allowed fast track especially those from developed countries that have similar resources. Their training and practice would most likely be similar to local practice. There needs to be some element of supervision and mentorship as there will always be differences in guidelines, medication and infrastructure that physicians new to practice in manitoba would need to received education on. As for titles, I think clinical assistants should not be using the title doctor as it can lead to confusion as to who is responsible for patient care. While I do recognize the training that many of the clinical assistants have their is also many backgrounds within that professions ranging from RT, RN, PA and MD. the position of clinical assistants is important and they should be respected as such however I feel that unless they are in the role of a practicing physician they should not use that title.

3

Thank you for requesting feedback on these important topics.

I have no feedback for 1 or 2, but do **NOT** believe the use of the title “Dr” or “Doctor” is appropriate for clinical assistants.

The title of “doctor” is not a criteria for designating merit or how good someone is at what they do. By the rationale provided below, all medical professionals (OT, PT, nurses, etc.) should be able to use the title “doctor” such that we honour the “professionals’ credentials through appropriate dignity and respect”.

1 2 3

Proposal 1: I believe this is an excellent change to allow for interested physicians to begin practicing in Manitoba.
Proposal 2: I also believe that this change will improve the transition to practice in family medicine.

Proposal 3. Absolutely not. There are too many "professionals" calling themselves Doctor with questionable backgrounds (naturopaths, anti-vaccine chiropractors) and adding to the mix a "doctor not doctor" will merely confuse the issue. Patients already do not understand the role of a PA or Cl A and adding a title of doctor to the Cl A is a terrible idea. We know which title will be held in patients' minds with any introduction.

Many foreign professionals with PhDs could be called Doctor even if not recognized here in Manitoba, and while that situation is difficult for them, their current profession is what is understood in current context, not what non-recognized credentials they achieved elsewhere.

The argument that the title could be used while in residency is spurious, as these individuals are no longer in residency. They have transitioned to another profession.

The rationale being to enhance "appropriate respect" is a workplace issue, not a title issue, and strong-arming the public or coworkers into deference due to an inappropriate title is ridiculous.

1 3

Thank you for forwarding the new CPSM proposed laws/ amendments for public consultations re:
1. Removing barriers to American Board Certified physicians to become fully licensed registrants at CPSM and
3. Allowing CA's to use the title of "Doctor"

The reasoning for the first of these changes are bound by current necessity to recruit specialists physician colleagues from south of the Border to bolster our Human Resources in expertise and numbers. I support the idea, but there are some provisos that need to the considered:
A. In the USA, Speciality American Board Certified physicians need to renew their Board certification every 10 years. This is done by undergoing a modified speciality Board exam again, or completing speciality courses required by the Board with certification over the

decade. If these physicians are recruited into Canada's workforce based on the Board certification, and unless they complete the recertification every 10 years, their Board certification becomes null and void. Would the CPSM then impose on them to keep up the American Board recertification if they decide to stay in the Province for the rest of their career? Note that this is not the Policy of the Royal College of Physician and Surgeons of Canada for Canadian Grads, although the idea had floated around in the past (of course, CME credit requirements have to be met). This is a consideration for CPSM, given that the American Board Certification does require renewal every 10 years, otherwise they become non-Board certified. I think CPSM need to have policy, should these physicians fail to renew their Board certification.

B. Given that our Human Resources for specialists tend to change, the potential impact of such a change in policy by the CPSM, in that this may reduce the chances and positions for potential recruitments of our own trained physicians in the future. Will there be a time limit for this change, eg. this amendment will be valid for only 5 years and not open forever. With increasing recruitment in our medical schools, I perceive that in the future we will have many of our grads trying to find placements in the speciality programs, and will face difficulties if the positions are occupied by non Canadian trained specialists. This change has to be temporary depending on our provincial needs.

C. Will CPSM review the past practices, complaints, legal action etc..of these potential USA specialist grads before being given certification in this province. I suspect caution and due process will be implemented.

D. The USA system of Medicine is quite different than ours in that in USA these practices and clinics may be run differently, with tiered benefits (private insurances, Medicaid etc) and with financial profits in mind, as compared to our socialized medical care and equality and equity for all our citizens. These physicians will have to be reoriented to our medical care system, and also to our daily patterns of practice, guidelines, names of medications etc. I think it is still important to have them undergo orientation with some period of observation prior to be given licences to practice right after their registration.

E. Had CPSM an overview of our specialist needs for each speciality currently? I think its is important to have this done, before the doors are open to USA Specialists, so that there is a limit to the numbers of recruited physicians depending on needs of each speciality. The need should be re-evaluated every 2-5 years

2. Re: CA's, yes if they have been certified as physicians in their original countries of training, I see no objection to have them continue carrying that title while working as clinical assistant here in Manitoba.

Thank you for the opportunity to express opinion and provide some input in those new amendments.

1 I would like to comment on the proposal to allow U.S. Board Certified Physicians to apply for full registration.
As an American-trained and certified physician who has successfully challenged the Royal College examinations and transitioned to practice in Manitoba, I am confident when I say that U.S.-trained and certified physicians are comparable to Canadian-trained and certified physicians. While there are differences in our training (for example, the Canadian emphasis on longitudinal psychotherapy hours and the corresponding de-emphasis of the same in American residencies), the overall process of

residency in the U.S. results in well-trained, highly competent physicians who are able to function independently and safely throughout the spectrum of healthcare settings.

The main barrier to care for U.S.-trained physicians will be adjusting to the Canadian healthcare system. The U.S. system has much greater EMR support, near-universal electronic prescribing, and much greater reliance on specialists for the management of chronic issues. Another difference that cannot be overstated is that the U.S. has more open access to specialists. Many insurance plans allow for patients to present directly to specialists without a referral from a GP, so the requirement for a referral will be something that American physicians may have trouble adjusting to. Many American-trained physicians will require substantial support in adjusting to the healthcare system in Manitoba.

Please don't hesitate to reach out if you have any questions about my comments, or would like further information.

3 I would be opposed to this change

1) In your rationale you state that these individuals have medical degrees and were able to use the title doctor during their training in other jurisdictions. Although this is an accurate statement it is not rationale.

I would assume that these folks were afforded this privelege on the assumption of successful completion of the training program to practise in their local jurisdiction. However for a variety of reasons this assumption was not fulfilled.

I can understand that this is disappointing to the individual. The solution is not a title change rather more opportunities for foreign graduates or those with incomplete qualification to access medical training and practice as physicians in Canada. This is the problem. Title changes are meaningless. These individuals need opportunities to increase their scope of practice and economic reward.

2) These professionals have completed a masters that qualifies them to be physician assistants/clinical associates. Differentiating them from other clinical assistants, who also hold advanced education, is in my mind an ill conceived idea. Either all get the title upgrade or none.

3) The rationale states that this would foster a more respectful environment.
I work with these health professionals and teach in their program. I was not aware that they are not afforded respect and dignity. If indeed this is lacking, oh boy, we need a different approach to improve the work culture. The title change risks backfiring and being seen as disingenuous by all.
4) Finally, I think patients will be confused and I cannot think of how to easily remedy this. Do we really want the professional having to explain they have a medical degree from another jurisdiction that allows them to call themselves a doctor but that their scope of practice is different than the other person on the unit who also identifies as a doctor? Sounds terrible. You compare this to the dentist

and chiropractor who use the term doctor. I think it is common knowledge that when seeking dental or skeletal pain care from a dentist or chiropractor, the scope is limited to this system. Same goes for the vet or psychologist who uses the title Dr with qualification. Perhaps you plan on a new and ongoing public education campaign to introduce people to this new rubric.
1 2 3 I apologize for replying from my personal email account instead of the work email ***** My feedback is as follows: I believe the suggested amendments will eliminate unnecessary obstacles for qualified individuals seeking to practice medicine in Manitoba: **1.** As a Canadian and American board-certified physician in general paediatrics and paediatric respiratory medicine, and an American board-certified physician in sleep medicine, I do not have any concerns about the first suggested amendment and believe it is appropriate. **2.** I do not have concerns about the second suggested amendment, provided that family physicians know their limitations and how to seek assistance. **3.** I am very supportive of the third suggested amendment. I work with a competent Canadian physician, and I believe he deserves to be referred to as Dr., even if it is used in conjunction with CA.
1 2 3 Hello, I have read your email of April 24 about: **1. Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants;** **2. Reducing barriers for Provisional Registration of Family Registrants;** **3. Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A."** I couldn't agree more with your proposal. I came here from the US in 2017 and taking the exams to become fully licensed was a huge hurdle. It is a huge detractor for physicians thinking of coming here. My question is: does this mean that Manitoba will fully license physicians without the MCC certification, or that they will get the MCC without taking the MCC exams if they are American Board-Certified? Just curious. I had to take the MCC exams to get the MCC, despite getting the CCFP due to having my AAFP. It did not make sense to me to have to take the MCC exams if I qualified for the CCFP based on having my AAFP. I am a very strong proponent of mentoring or practice assessment rather than exams as a truer evaluation method. I will not elaborate on all the reasons here. I would be a mentor, if anyone new came to my practice location. I am THRILLED that you are going to have an orientation. If you would like input from me about the things I had to learn the hard way, I am more than happy to help.

I am fine with the proposal about clinical assistants too, as long as they keep the clinical assistant on their name tags. That said, I do not work with any clinical assistants, so I really don't have a right to speak to this.

Thank you for taking these steps forward!

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2 Thank you for the opportunity to provide feedback.
My concern regarding the proposed reduction in the pre-requisite time in family practice from three years to 960 hours (approximately six months) relates to aptitude and comfort with preventative women's health care. We know that cervical cancer screening rates in our province remain lower than in other jurisdictions. In addition, given the distance of many communities from tertiary care centers, it is essential that family physicians are familiar with key procedures such as endometrial biopsy and insertion of IUDs and implants.
While I appreciate that, depending on the nature of prior practice, three years may not necessarily result in greater expertise in preventative women's health compared to six months, I would be interested to learn how the College plans to ensure that the breadth of previous training and practice captures competency in all required skills — particularly those related to preventative women's health exams and minor office procedures — that are vital for the communities we serve.

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1 2 3 Dear CPSM staff,
Thank you, again, for the opportunity to provide feedback on the following proposals. As ever I appreciate the CPSM's endeavours to incorporate Member's comments into deliberations.

1. Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants
- if the physicians are (a) board certified, (b) hold full licence / unrestricted licence, and (c) can have their regulator (the equivalent of the CPSM) provide a "Certificate of Good Standing" or similar *then I fully support the proposed changes*

2. Reducing barriers for Provisional Registration of Family Registrants;
- I fully support the proposed changes
3. Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A."
I understand the rationale, my only concern is that patients already struggle to distinguish/recognize the Cl.A. role is not that of a physician. If the Cl.A. is to use the title of Doctor, then surely the CPSM should just offer them a limited licence / restricted licences pathway, until they meet requirements of the practice ready process for full licence. *As such I do not support the proposed change.*

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1 2 3 I support all 3 changes.

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3 I have read the proposed changes for allowing clinical assistants to use the "Dr" designation. At present I do not think the general patient population even knows what a clinical assistant does and then to add the title would cause further confusion about provider roles.
I appreciate your continued work on improving our profession.

3 With regards to the third proposal, use of the title Dr for clinical assistants, and in consideration of the prompted questions: **Questions to consider:** *Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba?* *Do these changes negatively impact patient safety?* *Or are the current regulatory requirements appropriate?* I do not see any impact, either positive or negative, on the recruitment or ability to practice for clinical assistants in the province. I would be concerned with regards to a potential impact on patient safety, and the added confusion of yet another group of individuals referred to as doctor. If anything, patient safety and clarity could be better served with the reduction, not the increase, in individuals able to identify themselves as doctor. When working in the capacity as a clinical assistant, that individual does not require the title of doctor and is not working in the capacity of a medical doctor but under the supervision of one. This is not to say that their medical degree is not valid or is irrelevant, however in that particular capacity, the title of Dr. would be potentially misleading and confusing for patients and other healthcare staff. In this case the current regulatory requirements seem to be appropriate.
1 3 I support the proposals for licensure of American-trained physicians and for reducing barriers for family registrants. I do not support clinical assistants using the title of doctor. I think it is misleading to patients who already don't understand the differences between chiropractors, physicians and someone with a PhD. Thank you
3 In regards to the proposed change: 3) Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A"It makes no sense why the CPSM is engaging in this activity. Frankly, adding another health care associate to refer to themselves a "Dr." will lead to further confusion among patients, as opposed to "avoid confusion" as per the change. Of the other health care professions who use the title of "Dr." in MB, very rarely do they identify their profession. Just look ash their advertisements or online web sites. They do not include the post-fix designation. I've spoken to many colleagues in regards to this proposal. We all are in agreement that this is not a beneficial proposal and should be pursued further.
1 I am writing to submit my comments in response to the call for public consultation regarding regulation amendments. I am in strong support of the proposed amendment accepting US board certification as a pathway to full licensure. Having trained in both the US and in Canada, I have found training in most specialties to be comparable at least. Knowing several US-trained colleagues desiring to move to their home province of Manitoba for practice but facing several hurdles and given the current political climate, following in the footsteps of other provinces to recognized US board certification for full registration is a step in the right direction and will hopefully attract more physicians to Manitoba.
1 2 3 Thank you for the opportunity to provide feedback on the proposed amendments. Please find my comments below:

1) American Board-Certified Physicians
I have no concerns regarding this proposed amendment.
2) Reducing Barriers for Provisional Registration of Family Registrants
I fully support initiatives aimed at reducing barriers for International Medical Graduates (IMGs). However, I am concerned that the proposed requirement—six months of relevant experience within the past three years—may be insufficient given the realities of practice in Manitoba.
Physicians with provisional licenses are frequently placed in rural and under-resourced communities where clinical support and diagnostic infrastructure are limited. In such environments, the ability to practice independently and with sound clinical judgment is essential. Adequate prior experience—both in breadth and volume—is critical to ensuring safe, effective care in these settings.
Lowering the threshold for experience may also unintentionally devalue the work of those practicing rural generalism, by implying that such roles do not require extensive preparation or expertise.
3) Use of the Title "Dr." or "Doctor" by Clinical Assistants
While I appreciate and value the contributions of Clinical Assistants (CAs), I have reservations about permitting the use of the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A."
The public often associates the title "Dr." with licensed physicians, and may not fully grasp the significance of accompanying designations. This could create confusion about the scope and authority of Clinical Assistants.
As a younger, female, BIPOC physician, I have personally experienced situations where patients question my credentials or authority based on preconceived notions of what a physician "should" look like. Introducing another provider category with the title "Dr." may further complicate public understanding, potentially exacerbating these issues and requiring additional efforts to educate the public on provider roles.
Thank you again for the opportunity to comment. I appreciate CPSM's commitment to regulatory excellence and public safety, and I welcome further discussion on these important topics.

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Thank you for asking for feedback. I am comfortable providing feedback on two of the questions.

1. American Board -Certified Physicians

I agree with the proposed change. I have worked with three such individuals in my field and found both to be indistinguishable from my own practice. I don't see any reason to have them go through provisional registration since our standards are so closely aligned in training.

3. Allowing Clinical Assistants to use the title Dr or Doctor

I would be delighted to see this change. In Neonatology we have two CAs and to be honest they are both among our top performers. I have always found it distressing that they are unable to refer to themselves as doctors and specifically introduce themselves as such

when they are so talented. With the way our CAs function and knowing their background would allow them to be physicians in their home country I think it is a small but important gesture to let them know we value them.
3 While I appreciate the motivation behind the proposed change, I am concerned about the interpretation of such care by a patient. The role of clinical assistant is not identical with the role of independent physician (which general public typically associates with the label of "doctor"). I am concerned about the message given to the patient that their care is being provided by a physician. I have similar concerns about the physician in the clinical assistant role expanding the boundaries of their role. I am also curious about the choice of the label "doctor". I don't consider it a title in the sense of a credential. I would find it much more appropriate if the clinical assistant used their degree (MD or equivalent) beyond their name (as an educational credential). Choosing a much less formal and much less descriptive label "doctor" is concerning for me for reasons described above. I believe that the public's interpretation of the label "doctor" is equivalent with the physician role which is not equivalent to that of clinical assistant. See my signature at the end of this email that illustrates my credentials, my position and omits the generic title of doctor which I use in my role as clinician/physician when treating patients. In summary, I oppose the proposed change for reasons described above. Thank you for your consideration.
1 2 3 I fully support all three proposed changes to the CPSM General Regulation. These reforms are long overdue and much needed.
3 **Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction** While I fully support the use of a persons credentials because of the work and time that is required to achieve such milestones, I fear it will cause confusion for the patients that we care for, especially the elderly and for those who's first language is not English. It dose raise another questions for me as well: Does this also mean that a Physician Assistant that receives a Doctorate degree in public heath can use the prefix and introduce themselves as Dr. Joe Smith, Physician Assistant? (I have personal knowledge of 2 PAs that have completed Doctorate degrees, one of which works in Manitoba) With the Cl.As that work in Manitoba that have not completed a doctorate degree, will patients be confused by the difference in qualifications or the care they will receive? Will the Cl.A have to explain to the patient that he/she is not licensed to practice as an MD in Canada which may have the patient loose confidence in the care that the Cl.A is able to provide? I have also heard from some of my counterparts that the use of Associate Physician title is causing confusion for patients seeking health care due to the use of Physician Associate for the title of PA in Europe and which is being looked at as a change to the title in the United States.

3 Hello, I would like to give feedback on the proposed regulation amendments for international Physicians, specifically allowing Clinical Assistants to use the title Doctor. While I acknowledge that there are other jurisdictions and other health care professions using this title, most Physicians disagree with the widespread use of this title amongst non Physicians, and the escalating 'scope creep' of both this title, and health professions who are 'practicing medicine' both without actual training in medicine and without being held to the standards of medicine. More importantly, it leads to confusion for patients as the general public thinks of Doctor synonymous with Physician - specifically in the medical setting that Clinical Assistants will be working in – alongside Physician counterparts – this gives high potential for confusion for the public regarding who is the actual Doctor/Physician.
2 I am responding to the email from CPSM regarding the proposed regulatory changes aimed at reducing barriers to registration. I have observed some concerning trends, including the inappropriate management and rostering of patients. Furthermore, I believe that, at least in family medicine, we are nearing capacity. I've heard that the Family Doctor Finder list is essentially empty. At our clinic, a new physician who recently relocated from Ontario has been unable to find enough patients. Walk-in traffic has also dropped off significantly at several of our clinics. We must take steps to avoid repeating past mistakes—the pendulum continues to swing back and forth when it comes to physician supply.
3 I would like to respond to the proposed regulation amendments from three standpoints: 1) Physician perspective: I accept all of the proposed amendments except allowing clinical assistants to use the title doctor. Each time another profession elevates themselves by referring to themselves with a term that is used to also refer to physicians or taking over some of our easiest tasks then they are elevated above the status that they have earned by education, work ethic and accomplishments. At the same time, physicians are diminished. Ultimately the groups (in this case physicians and clinical assistants) will collectively be viewed by all as the average of the two groups. This is already happening as chiropractors are referred to as doctors, as are naturopaths. Physiotherapy clinics are advertising as "sports medicine." Nurse practitioners are grouped with physicians as practitioners. Pharmacists can now advertise for patients to come in for an assessment. What are the harms of what I have described above? Well, I have a patient who's practitioner has them stand on a pad while they hold a vial of liquid in each hand. Their "Practitioner" judges their condition based on the color change of the fluids and sells them a treatment for their imbalances. Pharmacists refill medications without assessing medical history, review of systems, renal function, electrolytes etc. They treat lower abdominal pain without a urine culture. Many of family doctor's easiest tasks have been given to nurse practitioners and pharmacists increasing the work load, complexity and burnout of physicians. At the same time the stature of physicians is diminished because so many practitioners are now thought to be on par with physicians. I won't bore you with the details as to why (let me know if you'd like to have that discussion) but this is leading to physician shortages and burnout.

We appear to have learned nothing from the exodus of physicians in the 1990's. We learned nothing from the burnout and suicide rates in medicine.

Here is the key point - these changes degrading the perception of physicians ultimately impacts patient care. Why would any graduate do family medicine as a residency when the ITDI nurses in my clinic earn the same as me but they have a pension, sick days, holidays and benefits?

If you feel strongly that this strategy is useful then do it across the board and remove the "Specialty" designation and treat all physicians with the same dignity. The breath of the family physician's knowledge and experience is equal to the depth and training of the specialist at 5 years post graduation. I understand this change won't happen but think about why it won't. The reasons are very similar to what I have raised above.

Consider also why we need clinical assistants and nurse practitioners. In large part it is contributed to by a lack of interest in the degradied profession of family medicine where physios, family medicine chiropractors, nurse practitioners, clinical assistants, nurse "specialists", naturopaths etc are all be elevated to the level of the family physician, which is at it's lowest point of public perception ever. That has harmed patient care.

I worked for awhile **********. I have worked in complex primary care for 30 years. I have provided hospital care, on call for hospital and clinic patients. I have seen the difference between a comprehensive family practice and some walk in clinic doctors. I have earned $300,000 while colleagues have billed 1.2 million. I know that not all physicians are working in a comprehensive, compassionate ethical manner but you must not see all of us as what you see in complaints and investigations. To represent a clinical assistant as a doctor is a misrepresentation. It smells of a lie pushed by positions and designed to placate the anxious public who cannot get a family doctor because the system is falling apart due to adequate care and respect.

I'm semi retired and will be done in a year - it doesn't matter to me what you do to family physicians. I have no children in the medical profession. I am thinking only of the patients.

If you will indulge me I would like to explain two more reasons why I am against this proposal:

2) I assume medical details in my letter will be kept in private. My wife had breast cancer and a mastectomy at **. At ** she had a second breast cancer and mastectomy. The latter had two distinct cancer with different receptor statuses. She had a positive node. She is BRCA2 positive. She had an oophorectomy. Melanoma risk and pancreatic cancer risk are significant. She is on anti-androgens and has an osteoporitoic fracture (age **). She has had chemo and radiation that carry their own cancer and other risks. She now has a 35 degree scoliosis and requires recurrent pain clinic injections. Hot flashes are more severe than I saw working at the Menopause

Clinic. I have witness suboptimal care and delayed care. I apologize that I cannot accept a clinical assistant to care for my wife - particularly since the need for this is inadequate care of the system. Government has contributed to this as have some physicians, CMA, CPSM and others.
I'm **, why don't I just retire? I need to earn a little more - *** of my *** children are BRCA 2 positive dramatically escalating their risk of male breast cancer, prostate cancer, pancreatic cancer and melanoma. We have told them we will pay for their IVF with pre-implantation genetic testing for BRCA 2. In addition to having worked at the Menopause Clinic, I also have done some work at Heartland in fertility. This will be expensive. How many clinical assistants will grasp the nuanced and complex care my family needs?

3) I get that this personal care info is cringy. Don't read on if the cringiness is too much for you - I am trying to strongly illustrate that I have a patient perspective. At 46 I had testicular cancer. My one functioning testicle was removed. I required androgen replacement. At ** I had metastatic testicular cancer and had chemo. I had pulmonary toxicity and had to stop Bleomycin. Cisplatin and/or etoposide caused peripheral neuropathy and tinnitus. Because of the large number of CT chest/abdominal/pelvis over those 12 years of surveillance and due to chemo risk of secondary cancers is elevated. At ** I had prostate cancer with an aggressive cribriform cell pattern on pathology. From the time my biopsy was positive and for a year my testosterone level was < 1. I had a lot of symptoms from that. I was gravely affected by near zero testosterone. It changed me. What would a clinical assistant do with that? I have experience in that area and I know what to do. I acknowledge that, like the clinical assistant, I would involve the urologist but the point is I understand the issues, symptoms, risks, treatments etc. I have a lot of complications, readmissions, ER visits and pelvic nerve damage - I cannot believe the symptoms I'm left with can be care for by a clinical assistant - even if you call them "doctor." I've had a cardiac ablation, a C4 fracture and lumbar foramina stenosis surgery. As with my family, I am a bit of a complex patient. I would not be comfortable with my care being provided by a clinical assistant. I would not be happy with the difference between the people involved in my care being blurred to hide who has what level of knowledge and skill.

I am a patient and I do not want government and government power bodies blurring the difference between my practitioners. I believe clinical assistants deserve the respect of clinical assistants. If clinical assistants are not respected - why aren't they? Use education to let the public know how knowledgeable the clinical assistant is. The fact that you want to hide who they really are is a concern.

Thank you for the opportunity to vent. I think burnout contributes to my crankiness. I have a strong appreciation for CPSM and their crucial work. I respectfully disagree on this issue.

Ps I also apologize for any typos - I was too frustrated to proof read this ;-)

1) American Board-Certified Physicians
I think it is a reasonable decision to remove barriers preventing qualified AB certified physicians from practicing in Manitoba.

2) Reducing barriers for Provisional Registration of Family Registrants I feel the pre requisite can be reduced, but to a moderate degree, 18 months instead of 3 years. Reduction to 6 month timeline might impede the clinical knowledge and acumen and certainly affect the clinical exposure of the candidate. I wonder if this would compromise patient care and also result in candidates being less effective point of care collaborators with consulting physicians. **3)** Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" I disagree with the proposal and I dont see the logic in the rationale put forth . Is it being suggested that a PA would gain more respect when using the title of Doctor. Yes, they probably would because it is a prefix that is not easily earned by a physician. It seems to undermines the effort that goes into medical training when the title can be casually bestowed on other medical professionals.
3 I wanted to reach out to provide my feedback and concerns regarding your proposed amendments. While I am in favour of reducing barriers to recognition of license and certification of our members, I am not in favour or support of the third amendment: **Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A."** Clinical Assistants, as a role, does not have the same responsibility (clinically and legally) as a licensed physician within Canada. Regardless of their clinical background internationally, acting as a physician is not in their lane or roles. Additionally, we deal with an incredibly disadvantaged, vulnerable and low literacy public demographics in Manitoba. If we are serving our patient well, we should not be endorsing in blurring the lines and misrepresenting their care. Medicine is already considered a black box. A lot of our patients do not get the proper care in regards to education related to their diagnosis, management or address of their concerns. This amendment lacks consideration of the patient perspective or the impact of this proposed communication and the dangers it poses to our patient population. The title of "doctor" is of incredible responsibility and one of extensive work and consistent commitment to obtain. I do not support this amendment. While I cannot vote against its use in other health care professional roles, I am asked to discuss its use here. Additionally, a clinical assistant is an extension of a physician. A CA role is not independent but instead are an extension of the most responsible and accountable. We must be mindful of the negative implications of the language we choose to use.
3 I am writing in support of the proposal to allow Clinical Assistants (Cl.A) to use the title "Dr." or "Doctor," provided they hold a recognized doctoral-level qualification. The use of the title "Dr." is an acknowledgment of academic and professional achievement, and many Clinical Assistants possess degrees such as MBBS, MD or equivalent. The ability to use a title values their expertise and contributions to healthcare in Canada. As long as the title is used alongside the full professional designation e.g., "Dr. Smith (Clinical Assistant.) there is minimal risk of public confusion. It promotes transparency and respect for academic accomplishment. This enhances patient trust and interdisciplinary collaboration. Moreover, many healthcare systems around the world already recognize and support the use of "Dr." by non-physician

doctorate holders, provided appropriate context is maintained. Aligning with this standard reflects a progressive and inclusive approach. I fully support this proposal and believe it upholds both professional integrity and respect for individual qualifications.
1 I am supportive of the move to recognize US trained medical specialists. I have done several US electives during my training and am regularly active in several US organizations associated with my specialty. I consider many US trained specialists as leaders in our field of practice. Consequently, I believe that Manitobans would be safely managed by US specialists who are granted a license to practice in Manitoba.
1 3 Hello, My feedback regarding the public consultation **1-** Removing restrictions that delay ABC physicians becoming full licensed As an International Medical Graduate, I believe that given this privilege to American certified physicians creates a two-tiered system that, for many IMGs, may feel discriminatory and inequitable. In this province there are highly trained physicians from countries outside the U.S. Who may have completed rigorous postgraduate training, passed board exams, and practiced safely and effectively and we are still required to undergo the Practice Ready Assessment, supervised practice, and obtain a provisional license before full licensure is considered. This discrepancy sends the message that training and certification outside the U.S. is inherently inferior, regardless of the physician's actual skill or experience. It may also send an implicit message to our colleagues that U.S trained doctors are more reliable than other IMGs. Patient safety is the goal, by exempting U.S.-trained doctors from the same assessments as other IMGs compromises the assurance of consistent care. Maybe there is a reason behind this special treatment to U.S trained MDs and if that the case, I would like to learn more from it to debunk my ignorance. I am open and will be happy to hear from CPSM. **2-** No comment **3-** Allowing Cl.A to use Dr. The title doctor should be reserved by licensed and practicing physicians in MB. Adding Dr. For the Cl.A may become very confusing for the patients and pharmacists. I don't think patients will appreciate this change. Thank you for the opportunity to provide feedback.
1 3 Regarding American physicians. I'm generally in support of easing the path to licensure and practice. I'm a bit concerned only in areas of specialty practice, where some of the requirements may (or may not) be different. I'd hope the college looks at individual cases to ensure that qualifications are very similar. With regards to the change and allowing C.As to call themselves doctor, as long as it is clear that they are C.As and still working in a supported environment I'm not too concerned. By the wording it would only apply to those with an MD degree from elsewhere.

3 Clinical Assistants are not practicing medicine in Canada, any more than nurses or other health workers are. They are practicing health care. 1. Clinical Assistants may have graduated from nationally approved medical programs in other countries, but we have no way to know whether they meet the standard of a person who is called a Doctor in Canada. We are talking about a person who is not licensed to practice as a doctor in Canada, that is clear. But we are also talking about a person for whom we have no proof that they have the knowledge and skills at the level of a graduate of a Canadian medical school. 2. It is harmful to the public to call Clinical assistants a Doctor (regardless of whether the term "Clinical Assistant" or another term is attached) because it obscures for the public the difference between types of health practitioners, and part of our mission is to make the health system easier to understand....more accessible in understanding and therefore promote clarity in interpretation and use. The onus is not on the people we serve to try to parse wording. The term "Clinical Assistant" is clear enough. The public should not be put in the position of making errors in their understanding of who in their care giving team has gone through the rigorous Canadian process of being granted the designation of "Doctor ". 3. It is totally inappropriate change regulations such that Clinical assistants may be called "Doctor" (attached to other parts of their designation).
1 I think American Board certified doctors should have minimal barriers to certification. I agree with proposed changes. I also agree with the other proposed changes as well.
1 2 3 1. Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants; No, as long as there are qualified IMGs in Canada who can serve Canada, I think the college needs to focus on IMGs who are already in Canada. 2. Reducing barriers for Provisional Registration of Family Registrants; Yes, that would be a great favor to all Canadians. 3. Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." Yes, this is a win win situation that improves the care and also trust between patients and health care providers. Thanks for asking us to vote.
3 I strongly support CAs and the importance of their role in health care setting. I don't support CAs using Doctor before their name. As a colleague I would be fine with CAs using Doctor designation, but thinking from the public's perspective I would urge caution. I feel many in the public would feel deceived. There is a high level of distrust, higher than I've seen in my career. I've been asked if I'm an actual doctor and had to defend myself. If a person is cared for by a CA, they should know they don't have an MD in Canada. Identifying someone as Doctor would lead someone to think they have these credentials in Canada.

If someone sees a dentist or optometrist, they aren't expected services a physician can give, so there would not be the same confusion.

If someone has a poor outcome, and learns they were cared for by a CA with a designation Doctor but without passing evaluations to ensure the skillset, they would have a legitimate complaint saying they didn't know the level of training from their caregiver.

I work with CAs and have many who have incredible skill sets, but occasionally some who really should not have Doctor as their title, and this could do harm.

It raises the question what does Doctor even mean? Certainly you need to do public education if you pursue this course.

Thanks for the opportunity to give input.

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1 3 Hi there, my feedback is:
1. Fully licenced USA Physicians should be fast tracked for licensure in Canada
Also CPSM should be advocating for National/Parallel Licensure, where registered Manitoba physicians can be eligible to work in all other provinces and vice versa.
2. No specific comment
3. Anyone who has successfully completed medical school has the right to use the title "Dr." but if they are working in capacity as a clinical assistant, this needs to be added in verbal and written communications.

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1 3 I think there needs to be a caveat re: accepting American board certified physicians immediately becoming licensed in Canada. IN some cases MDs will fail an FRCPC program repeatedly, and then apply to write the American board exams for specialties and easily Pass. I would suggest that if an applicant has written and failed the FRCPC exams, they cannot bypass our entire specialty credentialing system by simply writing a 4 hr ABIM exam and then becoming credentialed. Otherwise why would anyone ever write the FRCPC exams again? They are more time consuming, more costly and a great deal more difficult to complete.

1. I do not agree with Clinical assistants being able to use the term Doctor or Dr. in Canada if they do not have a Canadian Medical degree or equivalent. The term Doctor is a privilege and is earned and what is required to use that term is dependent on what any given jurisdiction decides is required to be an MD. There is enough confusion about the term amongst lay people and this only adds to that confusion as well as cheapening the value of the title here in Canada.

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3 Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." *if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction*.

I have concerns about the above amendment. While in writing this may be clear but introducing oneself to a patient as doctor may create patient confusion about their qualification is they are practicing in the capacity of a clinical assistant.

1 2 3 This is the feedback in response to proposed amendments. **1.** The physicians licensed with American Board should not have restrictions to practice. **2.** As a family physician I would not agree towards removing the requirement of work place based assessments or other pre-requisites required for provisional registration as I have concerns around patient safety. **3.** Clinical Assistant or associate or any Allied professional must not use the title Dr. as this can produce negative consequences with regards to patient safety and might increase complains too because of the unclarity of who the patient had consultation with. The title Dr. should not be mixed with any other allies. This title is granted in lieu of several years of Medical degree and should not represent anyone who is not formerly trained or did the full education. If for instance a clinical assistant has completed medicine degree in other jurisdiction they should be allowed to use the title once achieved full licence in Canada. This restriction will allow them to work towards gaining full licence. The thing which should be considered is that if clinical assistant has a medical degree and proof of practice in their hometown they should be allowed hands on practical assistance under supervision of clinician to speed up their license. Also the number of training years should be reduced on discretion of the clinician/physician they are working under(practice ready assessment).
1 2 3 I would like to provide my feedback on the new proposed rules. I appreciate the consideration and time for review of cpsm members. **1.** Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants: I guess it would be treated the same as IMG doctors. Making new regulations specifically for the US MDs wouldn't be fair for IMG doctors who have to do all requirements for several years to be licensed MDs in MB. **2.** Reducing barriers for Provisional Registration of Family Registrants; I believe the current licensing rules are pretty sufficient and reasonable to protect patients safety and well being. **3.** Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A. It could make lots of confusion and misunderstanding for patients as patients mainly couldn't differentiate the difference of a CA and MDs and it could potentially increase the rate of college complaints. At the end of the day, a CA should practice under supervision of a MD, so changing a title not only make any considerable difference, but also could cause unnecessary problems for MDs.
1 2 3 **1.** Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants; Makes sense. I also have to study American guidelines and exams and would just caution that their teachings tend to not have our element of 'choosing wisely', could this be part of some requisite courses pre registration? As well as Indigenous Health awareness and education I think those are two areas where our medical training are quite different. **2.** Reducing barriers for Provisional Registration of Family Registrants;

My preference would be not to reduce the timing of practice ready for IMG family doctors. The training differences I have encountered working with some fantastic PRA physicians is there is certainly a big difference in training. I have concerns that they may not meet safe training levels.

3. Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." *if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.*
Neither residents nor PA's or NP's generally make use honorific titles in their medical documentation or communications in Manitoba. To my knowledge and experience, CAs act on the same 'level' ie under direction/supervision of attending physicians who are titled "Dr". In my experience in navigating the hospital system the Dr. title is very helpful in identifying the Most Responsible Physician/Consultant when filing through large charts or EMR records. I would suggest a CA remain under the current nomenclature, just as a PA would sign "name, PA" or "name, MPAS" or a nurse with NP, or resident with PGY4/Resident. I see no workplace efficiency improvements with the title change and am concerned that a novice "CA" documentation may be confused with attending level charting/directives and delay urgent identification of key decision makers in patient care.

1 2 3

1 - agree
2- agree
3 - disagree. It is misleading to use the title doctor if not credentialed as such in the jurisdiction in which they are providing care

3

I would like to provide feedback regarding CAs using the title Doctor.

In acknowledging that other professionals use the title, including dentistry etc, I would also like to point out that those professionals are medico-legally responsible to those patients. The position of CA is unique in that the supervising physician is responsible. I feel that only those ultimately responsible for the end outcome of patient care should be allowed to use the title, as this confuses patients along with the placement of responsibility that should be respected. Therefore I disagree with this proposal despite the uptake in other provinces.

2

I have been involved in supervising the IMG psychiatry month during their year of rotating for many years and have supervised 100s of trainees. Quite often I am struck by the lack of knowledge in basic psychiatry. It is virtually impossible to fail these trainees and I fear for their ability to manage patients in rural unsupervised settings. I would see their being a need to enhance assessment, training and competence of IMG MDs not lessen the hoops they need to jump through. Training is quite uneven. For example, MDs trained in Egypt do virtually no psychiatry during their medical school and postgraduate training. Some IMGs are exceptionally well prepared for practice but I would say 10 to 20% are not prepared to treat mental health disorders after their year of postgraduate experience. In primary care mental health and addictions are a daily case and need basic expertise

3 I oppose the proposal to allow CAs to refer to themselves as doctor. I believe that this will confuse patients with regards to the role of the CA, and will undermine trust in the system if they find their care inadequate. To refer to yourself with the title doctor (medicine), you should have passed Canadian boards to do so.
1 2 3 The proposed changes appear to be reasonable ways of improving the number of physicians who can provide services for Manitoba. For proposal 1 and 2 (US licensed physicians and Family Medicine) - these are reasonable, but it is unclear if there is sufficient scope for evaluation of performance. From personal experience, the variability of the quality of training in the US is quite broad and more so than in Canada and this must be recognized and accounted for. If these are provisional licencensure (like in Ontario) with mandated evaluation of performance then that appears to be reasonable. For the Clinical Assistant - the complicating factor is knowing who the physician of record is. It is already somewhat difficult to determine if I am speaking with a physician or clinical assistant as this affects who I establish communication with and also for billing purposes. A form such as Dr. J Smith (CA for Dr. D. Jones), will address this concern.
1 I reject the proposed “Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants”
3 I am not in support of Clinical Assistants allowance of the term Doctor. Many clinics are already using a Physician extender and the confusion amongst patients is profound. They believe they’ve seen the supervising Physician but in reality they have seen a CA calling themselves the Doctor. We are watering down the respect of the medical profession by allowing these small differences to creep in. Just my two cents
1 3 While I agree with easy registration for American certified physicians, I do not see any mention of discipline records. An example might be an American physician who is licensed for practice but is restricted by their state medical board to seeing males only due to past sexual misconduct. I would think we would exclude physicians with active restrictions on their licence, or previous censures that CPSM finds unacceptable. I would also ask why we would not make similar changes for British, Australian, or New Zealand certified physicians? These are all English speaking countries with similar medical systems to ours. My other concern is not with the changes, but how we assess international medical degrees: "(i) a medical degree granted from a nationally approved faculty of medicine"

My understanding is that this is derived from the world directory of medical schools. I'm not sure what accreditation processes this organization uses, but in my experience working with foreign trained physicians there is enormous variability in knowledge and competence. I do not believe that every medical school that is in the directory can be considered equivalent to a Canadian M.D. For example, Afghanistan is listed as having 41 faculties of medicine. This is a country that has been at war for decades, has excluded women from education, has a similar population as Canada, but somehow has double the number of medical schools as Canada. I find it difficult to believe that the Alberoni University Faculty of Medicine near the small city of Golbahar, Afghanistan, with a 70 bed teaching hospital is equivalent to McMaster or UBC.
3 My name is *****. I have been a clinical assistant for over 10 years. I am very glad that a Dr. Can be added to our title. Since I have been an LMCC since 2013, I also hope that we can be entitled to work as an associated physician if we hold an LMCC or a Canadian specialty license, which is similar to the policy from other provincial colleges such as CPSBC.
3 I agree with using title of Dr for Clinical Assistant who are medical graduates outside Canada. On the other hand, in some other province they are addressed as associate physicians which we may be able to expand for this too.
1 2 3 I am an associate registered member of CPSM as a PA. In relation to proposal for 1 and 2, I see no issues in reducing barriers in seeking Canadian registration, provided accreditation standards are maintained. My only concern in this arena is that with the political climate changing swiftly to our south, accreditation bodies may struggle to maintain objective lenses without influence to meet demands of their government. In the future, graduates from programs that have conceded DEI and other policy-based admissions and credentialing criteria may not produce the same 'type' of clinician or socially safe and empathic clinicians if they were raised in more hostile and anti-DEI rhetoric environments, which could impact the psychological safety of Canadians. Something to consider when re-evaluating the merit of accreditation and whether there's been shifts. In relation to proposal 6(9), I disagree with the consideration that Clinical Assistants be able to also include "Dr." or "MD" in their names. Cl As and PAs are often clustered together as mid-level providers and are distinct entities from physicians. Being relatively new to the Canadian health team market, the public is still acclimating to the existence of PAs and CAs. There is still a lot of confusion around how to conceptualize where these roles fit within people's constructs of health teams. Adding in nomenclature that positions CAs as a variant of MDs, would further complicate this, leading to muddying of all CAs, PAs in the eyes of the public. If we are trying to establish these career trajectories as independent professions, there needs to be clear separation of mid-levels from full phyisicians. Once the CA completes their pathways, MLP-IMG programs, etc, then it would be completely appropriate. But before that, not all CAs have their MD, and I don't see any gains beyond acknowledgment of past (though potentially not parity to Canadian standards) educational achievements but if they're not practicing at that level, they should not be mis-representing themselves as "dr" when introducing themselves, nor signing off on things that a CA does not have privileges to do, and it could lead to a pile of

complaints, safety breeches and role creep. I was formerly an ICP paramedic, but rescinded that title when I completed my PA training. This would be like me signing off on patient transfer records as an EMT, because I formerly held this title, accredited by an institution, but don't practice at that level anymore. It would be inappropriate. Kind regards, thank you for the opportunity to provide feedback
3 This email confirms my agreement regarding the appropriate use of professional titles for Clinical Assistants within the jurisdiction. Clinical Assistants who have obtained a medical degree from a nationally recognized institution outside of our jurisdiction are permitted to use the title "Dr." or "Doctor." However, to ensure clarity and proper recognition of their specific role, this title must always be followed by the designation "Clinical Assistant" or the abbreviation "Cl.A." This practice will facilitate clear communication and ensure appropriate recognition of their qualifications and current responsibilities.
3 Hello again! I recently sent an email with my concerns about CAs being able to use the title "Dr." My main concern is that patients will be confused as to who is the most responsible "Dr."on the team caring for them. I would like to add that despite the fact that other professions such as dentists and chiropractors and naturopaths (ugh…still not quite sure about that one, but maybe I need to educate myself more about that healing profession) use the title "Dr.", I believe that their patients understand that they are a Doctor of dentistry or chiropractic, belonging to a Canadian professional college that registers them and holds them accountable for the all of the decisions they make, as the head of the team they work with. ie: they are understood by their patients to be a certified, registered and fully independent and accountable HCP, meaning the buck stops with them and the patient can rely upon the "Dr. " title to promise them that. As a physician who works with learners, PAs, and CAs, I have seen the confusion and even fear that misunderstandings about who the most responsible "Dr" is can cause. Despite the PAs and CAs being excellent, completely reliable and responsible HCPs that I fully trust and rely on, patients have ended up feeling mislead or even betrayed by the "Dr" title. (Not that the "Dr" title is routinely used for PAs or CAs where I work, but my particular patient population frequently does not understand the nuances of a non-Canadian-licensed MD, and despite our best efforts to explain, inevitably a patient will refer to a PA as a "doctor" and other patients will then think that PA/CA is a "Dr" as they understand myself to be. Now that we have had PAs/CAs for years, the community is beginning to understand what a PA/CA is, but there has been a lot of confusion along the way, especially with the rotating nature of our medical/PA/CA team here in the north). My patient population is a vulnerable one, and I suspect that a more socially-advantaged and higher-educated population might appreciate the nuances about a "doctor" with certification from another country/jurisdiction, not yet Canadian-licensed. I have seen it many times where the title "Dr" for a non-Canadian-system licensed MD has led to confusion and erosion of trust, as I mentioned above.

I believe we need to protect the title “Dr” when it comes to Canadian-licensed physicians as the nuances can be confusing and even harmful to certain patients if they believe their PA/CA is the Canadian-licensed, most responsible “Dr” they expect them to be, but are not technically licensed as the patient expected; ie: “stamped” with the legal, Canadian-licensed and authorized “seal of approval”. This is subtle, I know, and likely only applies to the more vulnerable patient populations like the ones I work with, but this makes it even more important to ensure this particular patient population is not inadvertently mislead about who they think are their “Dr”s, as trust is so fragile at the best of times, and these vulnerable populations tend to be over-represented in acute care settings like ERs and Urgent Cares where there is no time to explain the subtleties. Confusion in these settings is dangerous as there is no time to deal with these subtleties due to the nature of the care environment, and patients’ misunderstandings or feelings of betrayal can lead to more distrust in the long run, leading to more health problems and care burden in future, like the proverbial snowball. Thank you for taking the time to listen to my thoughts.
1 2 3 I'm supportive of all 3 changes one comment re using Dr for CAs……while I have no problem with this change, it is potentially confusing (to the public for sure and possibly to people in the system)
3 Thank you for the opportunity to provide feedback. Regarding: “Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A.” *if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.”* I am not in favor of this amendment. I provide this feedback in the context of having directly supervised several Cl.A.’s with medical degrees from other countries, as well as having supervised PhD graduates who are also eligible to use the title “Dr.” My reasons for not supporting this are as follows: 1. Cl.A.s are not working in the capacity of a physician, and therefore should not use the title “Dr.” in that work – regardless of their previous training. If they were working as a physician, they can call themselves “Dr.” If they are working as a clinical assistant, they should refer to themselves as “Clinical Assistant” 2. When a Cl.A. uses the title “Dr.”, it is misleading to patients and staff. We tried this with one Cl.A. who was under my supervision and working on our clinical team. It led to confusion with patients and other members of the multidisciplinary team, in terms of role clarity and treatment expectations. Especially with patients and families, transparency and accuracy are of utmost importance. 3. An analogous situation would be a medical student who has already completed a PhD prior to medical school. This student would not introduce themselves to patients as “Dr.” while on clinical rotations in clerkship. Regardless of previous training or degree accomplishments, a provider uses the title that fits with their current role in that setting.

4. Unless we have rigorous evidence that supports that Cl.A.s using the title Dr. improves recruitment and retention of internationally trained physicians in the MB healthcare system (compared to not doing so, or compared to other jurisdictions) – we should not make that claim.

I hope the above is helpful. Thank you again for the opportunity to provide feedback.

3

Thank you Kindly for an opportunity to make a contribution about the three proposals.

I must mention that two of these proposals directly affects me.
I do supports removing restrictions for American Board-Certified Physicians becoming fully licensed and reducing barriers for Provisional Registration of Family Registrants, in addition to allowing Clinical Assistants to use the title Dr. or Doctor.
As a Clinical Assistant, I often found it difficult to explain to my patient why I am not a resident doctor and not a Physician Assistant. Many of them become embarrassed that they allowed themselves to seen by me in the first instance. The conversation usually end up as I am a foreign trained physician but not licensed to practiced independently. The word Clinical Assistant could be misleading and sometimes people with little command of English may not even understand until you say 'I am assisting Dr A or B' and you can now be accused of impersonation due to the language barrier. If C As are allowed to use the word Associate Physician it will be easier for them to perform their duties.

Furthermore, I have practised independently for 980 hours over a period of three months plus over the past three years and I have passed TDM. I have also practised dependently as licensed C A for over 2000 hours over a period of 12 months within the pass three years. I believe if these proposals were already approved, I might have had opportunity to be assessed for a practice ready assessment.

I would be willing to appear in person if acceptable to shed more light about my position.

1

I generally support simplifying the process for US physicians however there are a few cases scope of practice are not equivalent

For geriatrics specifically US training is 1 year vs 2 years in Canada. It is a primary care specialty whereas we are consultative in Canada
Many geriatricians in the US will have an equivalent scope of practice to us however it is also possible that an individual arrives with a much more limited scope. A quick review of their practice pattern would suffice to ensure equivalent practice experience

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1 2 3

1. I agree that a board certified American doctors should be allowed an expedited process to get licenced in MB.

2. I have mixed feelings about allowing registrants earlier access to a provisional licence. I feel like it greatly depends on the quality of their previous training and competency rather than the length of time spent in practice.

3. I feel like allowing CA's to use the title Dr or doctor would add to an already existing confusion in the medical field. My patients already (and myself often included) are confused about the roles of PAs vs CAs vs NPs. Patients often think they saw a doctor when they actually saw the PA in the ER. I feel like if staff are equally confused, it may lead to patient safety issues. I also don't really understand from the description who would actually fit into this category.
3 ***Feedback Letter 1 attached***
1 2 3 ***Feedback Letter 2 attached***
1 2 3 I have reviewed the proposed amendments and am OK with them in principle.
2 3 Regarding the following proposed changes: **1.** Removing restrictions that delay American Board-Certified physicians becoming fully licenced registrants; **2.** Reducing barriers for Provisional Registration of Family Registrants; **3.** Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction. I have no opinion on the first proposed change. I would be in support of the second proposed change. I believe the third proposed change could result in additional confusion around the use of the title "Dr." and the lay public may not fully understand the nuance of use of a conjunction.
1 2 3 **1.** Agree. It seems reasonable to expedite approval of board certified American doctors here. In my experience (taking the American board exams for my specialty and current CME from and in the states) I believe the training to be equivalent. **2.** I do not agree about the decreased practice time requirement for a provisional license. Maybe a decrease is needed but based on the provided math this is changing from 36/60 months (so around a 0.6 eft) down to 6/36 (0.2). Even with quality training it would be hard to truly maintain competency at such a low minimum of practice time. **3.** Strongly Disagree. We are a self regulating profession. To call ourselves Doctor means we have taken an oath to hold ourselves to a higher standard. We trust the college to maintain this high level of competence, and that includes the current credentialing processes. There is already an established pathway for Clinical Assistants to follow if they wish to obtain full credentials in MB and subsequently be addressed as Dr. Simply expanding the title of Dr to Clinical Assistants would negate the current processes in place and actually

undermines the efforts of those Clinical Assistants who have appropriately proceeded through the system to show their competency and meet the standards that have been set.

It is understood a Dr is an expert in their field, but the examples given of other health care professionals who also use Dr are not actually applicable here. The title is highly dependent on context of use. If you make an appointment to see the chiropractor, when they introduce themselves as Dr you know they are the ones responsible for your chiropractic treatment. Similarly at the dentist's office there may be many people involved, hygienists cleaning for example, but when you meet the Dr it is understood they hold the authority to make the final treatment decisions for your teeth at that visit.

So, when patients come into any medical setting (clinic or hospital) as soon as the title Dr is used it is assumed that that person holds the full medicolegal responsibility for their care. Our patients will not understand the implication of the qualifier, and using the title Dr in this setting is ultimately misleading.

Why does the college want to expand this title? The title Dr imparts full medicolegal responsibility and authority and is much more than simply a term of respect. In the email the college states that this title expansion is to recognize these professionals with dignity and respect, which is an issue that should be independent of title. All members of the health care team should be treated with dignity and respect. Applying the title of Dr is not necessarily an appropriate solution to placate concerns of treatment otherwise. It is confusing and misleading to patients and likely would not solve the underlying issue that seems to be driving this proposed change.

3 *Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba? Yes*
Do these changes negatively impact patient safety? No
Or are the current regulatory requirements appropriate?

I am emailing in regards to the recent email about allowing Clinical Assistants to use to title "Dr" and to voice how concerned I am about this.
Clinical assistants have not gone through the same training as Canadian grads, and it is my experience working alongside them that their knowledge base, ability to develop a differential and create a safe management plan - are frequently lacking. I have not yet worked with a CA that has not required significant guidance and oversight from a medical doctor while practicing.

Their use of Dr will mislead the public into believing their skillset is as honed as Canadian Doctors, which is simply not true.
Please reconsider this proposed amendment.

1 3 In my opinion, It is not sufficient to be ABIM certified or having trained in the US in order to be elligible to practice medicine in Manitoba. While medicine is medicine, there is still differences between countries. Having done my own residency in the US (internal medicine) I can tell you that I learned a lot after having done my fellowship and completed my training and exams in Canada.

In my opinion again, the programs across Canada are quite comparable to each other when it comes to level of training. However, there is variation in each of the residency programs in the united states that some have better trained physicians then others. I imagine similar arguments can be made for family medicine. In regards to calling a clinical assistant Dr., I have no problem with that as long as well don't confuse them with their MD that they are seeing.
1 3 I support removing restrictions that delay American Board-Certified physicians becoming fully licensed registrants and for reducing barriers for Provisional Registration of Family Registrants. With respect to Clinical Assistants using the title "Dr.", I think it should be restricted to those IMG's who are registered and are participating in the MLPIMG Program. For those internationally trained physicians who are not seeking licensure, they should continue to use the title CA (Clinical Assistant) alone. Thank you for the opportunity to respond.
2 3 ***Feedback Letter 3 attached***
1 2 3 1) I would go along with: Removal of Restrictions that delay American Board Certified Physicians becoming Fully Licenced Registrants. 2) I would agree with Reducing barriers for Provisional Registration of Family Registrants. 3)I would agree with allowing Clinical Assistants to use the title "**Dr.**" Or "Doctor"', in conjunction with "Clinical Assistant" or "Cl A", if they have a medical degree from a nationally approved faculty of mediciine in another jurisdiction.
2 3 I would like to propose a reconsideration of the current status and designation of Clinical Assistants (Cl.A.s) who hold medical degrees from nationally accredited faculties of medicine in other jurisdictions. Many Clinical Assistants in Manitoba have extensive medical training and experience, and they work in academic teaching hospitals across various high-demand specialties, including psychiatry, internal medicine, and primary care. **Despite this, they are not currently permitted to use the title "Dr." or "Doctor"—even though patients frequently refer to them as such**. In contrast, medical residents, who are still in training, are routinely addressed as doctors. This discrepancy causes confusion for patients and does not reflect the level of expertise and responsibility these professionals carry.

The term "Clinical Assistant" is misleading and does not accurately convey their qualifications or role. A more appropriate designation—such as "Doctor in Training" or "Clinical Associate"—would better reflect their status and clarify their position within the healthcare team.

I also propose the following steps:

Title Recognition:

Permit Clinical Assistants with internationally recognized medical degrees to use the title “Dr.” in conjunction with their formal role (e.g., “Dr. [Name], Clinical Assistant/Associate”).

Structural Reform:

Create a distinct affiliated body within or alongside the College of Physicians and Surgeons of Manitoba (CPSM) to represent and regulate Clinical Assistants separate from Physician Assistant, with the goal of better integration into the provincial healthcare system.

Pathway to Licensure:

Design a structured, accessible program—especially within primary care—that supports Clinical Assistants in achieving full medical licensure. This could operate in parallel with or as an expansion of current programs like MLPIMG, which is presently limited in scope and accessibility.

Cost Savings for Manitoba and System

Efficiency: Better utilization of this highly skilled workforce would not only alleviate physician shortages but also save the MB healthcare system significant costs by reducing the need for locum or contract physicians.

Re-training

Cl.A. within the system is more cost-effective than fully training new physicians from scratch.

T**he Manitoba government could save millions** in training and recruitment costs by leveraging the skills of already-available, partially integrated physicians.

Manitoba continues to face physician shortages, particularly in family medicine, general internal medicine, and psychiatry. While initiatives like the Medical Licensure Program for International Medical Graduates (MLPIMG) and the Canadian Resident Matching Service (CaRMS) offer some pathways, these are limited in scale and insufficient to meet current and projected demand.

At the same time, many Clinical Assistants (Cl.A.)—internationally trained medical doctors—are already working within the healthcare system under supervision, often in academic teaching hospitals. Despite their clinical experience and medical education, they face redundant retraining or barriers to entry into the formal licensure process.

Thank you for considering this important matter.

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1 2 3

1. I agree for americal board certified doctors should get license to practice easily in MB.
2. Registration process should be faster.
3. Internationally trained doctors working as Clinic assistants should not be addressed as doctor when they are working under a practicing physician's license. Untill clinical assistants goes into appropirate training to get qualified for CPSM license. I had a Clinical assistant , she was introducing herself as a doctor behind my back, without my knowledge. She started sigining prescriptions as herself being doctor and also started forging my signature. I caught her when manager from Massage therapy center, where patient took Rx for massage, called our clinic asking for clinic assistant's license number,since clinic assistant signed rx as Doctor for massage Rx. I fired her and reported to CPSM. Unfortunately CPSM accused me for clinical assistant's fraud and forgery. Clinic assistant who posed as a doctor when she was working under me as clinic assistant and stolen my identity , she was never got investigated by CPSM for her act.

If Clinic assistants wants to be called as doctors they should have their own license number and they should be held accountable for their own actions, not accusing their supervising physicians.

If Clinical assistants are allowed to be addressed as doctors , patients will be misguided as they saw a doctor, if a mistake occurs in patient care , supervising physician will be punished and face concequnces not clinical assitant as supervising physician hold license not clinical assitant. Introducing clinical assistants as doctors will be a fraud to patients.

Clinical assistants should never be referred or addressed as doctors before getting license to practice by CPSM.

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1 3

Re fast track of US graduates. So long as training and competencies are deemed equivalent to Canadian graduates. There are some training which is very different than in Canada eg Int Med/Peds combo. These nuances needed to be accounted for in type of practice in Canada. Same standards should apply to US citizens as to any other country. I am not sure how it will be perceived by other countries to have the amendments framed as presented. Implied assumption of equivalence

Re CA and use of Dr. Title. If gained title of Dr through PhD or MD route any where in the globe should be able to use the title. Introductions of current clinical role as CA would then need to be made explicit including the under supervision of Dr X.
No other comments re other changes

3 **Proposal: Allowing Clinical Assistants to Use the Title "Dr." in conjunction with their Designation.**

Clinical Assistants (CAs) are important "CPSM-registered" healthcare providers in Manitoba, and they hold medical degrees from nationally accredited institutions abroad and possess years of post-qualification experience. Most have also passed required Canadian exams (e.g., MCCQE), and the Medical Council of Canada (MCC) itself uses "Dr." in correspondence and certificates issued to these IMGs.

Despite this, CPSM currently prohibits IMG CAs from using the title "Dr." or "Doctor"—even after verifying their credentials and good standing with their home regulatory bodies. This restriction persists despite their prior use of the title as licensed physicians abroad and their ongoing contributions to Manitoba's healthcare system.

Key Concerns
- Patient Perception & Care Barriers: The current policy inadvertently diminishes patient confidence, as CAs are often mistaken for medical office assistants rather than trained professionals working under physician supervision.
- Professional Dignity: Denying the title disregards their qualifications and experience, creating unnecessary inequity compared to other regulated professionals (e.g., dentists, optometrists) who use "Dr." in Manitoba.
- Jurisdictional Alignment: Provinces like BC, Alberta, and Saskatchewan already permit CAs to use "Dr. (Clinical Assistant/ Associate Physician)", ensuring clarity without compromising scope-of-practice boundaries.

Proposed Solution:
Allowing the title "Dr." or "Doctor" only when paired with "Clinical Assistant" (e.g., "Dr. Smith (Clinical Assistant or Cl.A)"). This:
- Upholds transparency about their role and supervision requirements.
- Aligns with CPSM and MCC's recognition of their credentials.
- Boosts patient trust while maintaining regulatory safeguards.

In Conclusion, this change would affirm CAs' expertise, improve team dynamics, and align Manitoba with progressive practices elsewhere without risking patient safety or scope of practice violations. We urge CPSM to adopt this reasonable, dignity-preserving amendment.

This is my feedback for the proposed CPSM amendments:

1. Removing restrictions that delayed American Board-Certified physicians becoming fully licenced registrants;

1. In general, I support the CPSM's attempt to:
    1. Address the physician/health human resource/care crisis in Manitoba,
    2. Capitalize on the US political climate and trend to push away its most educated, particularly its physicians, and
    3. Stay competitive among the P/Ts by attempting to harmonize medical practice restrictions to what the other P/Ts are doing.
2. However, this approach:
    1. Is short-sighted and creates a fast track specific to US-trained physicians while ignoring all other countries' medical training programs;
    2. ignores the big and complicated picture of medical licensure in Manitoba (and Canada), particularly the gaps inherent
        1. within the CPSM's current system of regulations, practice directions, and policy implementation (eg policies that are at cross purposes with each other, variation/inconsistency of policy application) and
        2. Between CPSM policies and medical compensation models, medical education system, and interplay with allied HCPs (regulated and non-regulated); and thus
    3. Further Increases inequities and barriers faced by 2 groups of medicine-trained in Canada and Manitoba face:
        1. Canada-trained Public Health and Preventive Medicine (Community Medicine) specialists
            1. Most Manitoba/Canadian-trained PHPM specialists have both CCFP and FRCPC designations (and are unique as the only 3-for-1 residency with CCFP, MPH/MSc, and FRCPC training/designations built into the program)
            2. PHPM graduates in Manitoba most often take on Medical Officer of Health positions with the Government of Manitoba which carries a significant clinical practice component in addition to population health
                1. this clinical component rose significantly during the pandemic, and over 5 years, it was virtually impossible for Manitoba's core PHPM specialists to be able to maintain clinic "Family Medicine"-type shifts while also working on Manitoba's COVID response
            3. While PHPM is a relatively small specialty, the political nature of this specialty carries a high risk of harassment/bullying, burnout, reprisal, and termination for its practitioners, forcing many to seek alternate work (most often clinical in nature)
            4. Manitoba-trained PHPM specialists face unnecessary impediments to practice medicine in a clinic despite:
                1. Having NEVER LEFT MEDICAL PRACTICE IN MANITOBA;

2. being trained by Manitoba Family Medicine program and keeping CCFP designation current;
3. Keeping full specialist registration current and in good standing; and
4. Community Medicine specialists being specifically denoted as being able to claim tariffs under the Internal Medicine bloc p87 of the Manitoba Physicians' Manual:
    1. 11 The above tariffs and benefits can also be claimed by those physicians who are Fellows of the Royal College of Physicians and Surgeons

of Canada in Community Medicine and whose names are on the specialist register of The College of Physicians and Surgeons of Manitoba
(Rule 2).
April 1, 2025

2—SPECIALIST
A ***Specialist*** (for the purposes of application of the Schedule of Benefits) shall be defined as a physician whose name is in the specialist register of The College of Physicians and Surgeons of Manitoba and shall be paid according to the listed benefit in the Schedule of Benefits for that specialty.
A ***Specialist*** is permitted to do and shall be paid for a procedure outside his specialty.
Where there is no "office and hospital visit" page for that specialty or where the procedure has been done by a specialist which is not listed in the "office and hospital visit" page of that specialty, payment will be made according to the general practice schedule except tariffs specifically mentioned elsewhere in the general schedule.

5. This is due to the CPSM's
    1. lack of recognition of PHPM specialist practice as clinical practice;
    2. Assumption that any clinical practice of PHPM specialists must be considered as "Family Medicine";
    3. Prohibitive Interpretation and Application of Practice inactivity and Re-entry direction

2. racialized IMGs/IMGs trained in racialized countries.
    1. Australia, Ireland, UK, and US-trained physicians have less restrictions to practice compared to other countries
    2. IMGs currently in Canada but who were unable to get registration as soon as possible face increasingly larger barriers to get any registration/ability to practice Medicine in Canada
        1. Many describe having to go back to their original country to maintain practice to remain current in Medicine just to keep trying to enter the Manitoba medical system, so
            1. Manitoba/Canada is missing out on these doctors' contributions to serve the public,

2. the racialized communities further miss out on having physicians/HCPs that look and speak like them

3. *Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba?*

The proposed amendments preferentially remove impediments to non-Canadians (specifically US physicians) over physicians currently in Manitoba. I caution the use of "US" specifically and would push for

1) a review of Canadian medical licensure requirements with an anti-racist, DEI lens
2) amendments that remove unnecessary impediments for physician licensure overall, with a focus on physicians in Manitoba before US physicians
3) work to address gaps between CPSM, medical education, compensation models, and DRMB
4) pan-Canadian medical licensure/harmonization of interprovincial physician restrictions

If instituted, the proposed amendments should be generalized to remove impediments for physicians currently in Manitoba and ensure the Manitoba-trained/Canadian-trained PHPM specialists are approved to practice Medicine clinically and in a clinic without onerous and prohibitive application of the re-entry/inactivity policies that negatively impact patient care/serving the public. Specialized facilitation of Manitoba residents who are IMGs not yet in the system to contribute to the care crisis in Manitoba would be a great initiative I could assist with (my MPH studied this issue and COMO work included experience in assessment of training programs).

Do these changes negatively impact patient safety?

- Specifically removing barriers for US physicians over Manitoba/Canadian physicians could negatively impact patient safety. Addressing the system issues/gaps to enable those physicians already in Manitoba to practice optimally would lead to the best patient safety outcomes.
- Caution and consideration should also be given to make any US-specific policy change time-limited. While currently, US-trained physicians are close to on par with Canadian-trained physicians, this could be very different in several years with the gutting of educational programs, funding, etc of the universities in the US. Blanket removing barriers to US-trained physicians doesn't take into consideration the marked differences in states, the political climate of the current US administration (and concerning support for the Trump administration), and the quality of future doctors trained in the US. I would like to see improved facilitation of licensure/removal of barriers for the countries Canada is partnering with currently. It seems not values-based to cherry pick and make it easy for US doctors and not give equal opportunities to doctors trained in other countries who respect Canada.

Or are the current regulatory requirements appropriate?

No the current regulatory requirements should address the gaps and problems inherent in Manitoba's Health Care system that contribute to the care crisis from both the public/patient and physician perspective.

2. Reducing barriers for Provisional Registration of Family Registrants;

1. I support any removal of requirements to Family Medicine registrants, having been subjected to the current onerous and expensive process which PHPM specialist colleagues have found prohibitive.

I recall the removal of the 1 rotor GP internship year in favour of longer residencies (and 2-year family medicine specialty program), and I support bringing something like it back. Keeping the massive burden of primary care solely on Family Physicians' backs further increases burnout and the care crisis. Allowing our body of current physicians to practice in different settings (including primary care) takes advantage of using staff already familiar with our system and decreases the siloes between specialists and family doctors.
Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba? Yes
Do these changes negatively impact patient safety? No. We are already dealing with patient safety issues from major lack of family medicine registrants.
Or are the current regulatory requirements appropriate? No.

3. Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction

    1. *Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba?* Yes

Do these changes negatively impact patient safety? No.
Or are the current regulatory requirements appropriate? No. Anyone with an MD should be called Dr. Same with PhD. Physicians should not be "demoted" crossing into Manitoba.

Stakeholder Feedback

2 Dr. Holly Hamilton, Director Practice Ready Assessment, University of Manitoba Holly.Hamilton@umanitoba.ca
The public consultation in reducing barriers for provisional registration includes "a total of at least 960 hours of direct patient clinical practice experience in family medicine in the preceding 36 months,"
We recommend that in addition to the recently of practice a " total of 2 years of independent practice since post grad training" be included, as ensuring a history of independent practice is predictive of a successful outcome. I appreciate your consideration.
Feedback Letter 4 attached

1 2 Meret Shaker, College of Pharmacists of Manitoba m.shaker@cphm.ca
Feedback Letter 5 attached

1 2 3 Chantelle Dick, Program Manager, Standards of Practice: on belhalf of CPSA Chantelle.Dick@cpsa.ab.ca
On behalf of CPSA, thank you for the opportunity to review the regulation amendments.
Our Registration Team provided the following feedback:

1. The only question raised was in regard to focusing on the US as the only jurisdiction for this consideration and not all jurisdictions from the Royal College's and CFPC's lists of Approved Jurisdictions.
2. Verifying a minimum number of hours is essentially impossible for an MRA: AB also uses practice in the last 3 years, which can have a broader interpretation for a relatively arbitrary definition of currency.

3. The title "Dr" is based on successful completion of a doctoral degree, so removing that restriction is entirely appropriate; however, if the issue is facilities where they are employed wanting or needing to differentiate them from MRPs, perhaps this is a privileging concern, not regulatory. Please let me know if you have any questions or require additional information.
1 2 3 Jill Brown, Assistant to CEO: on behalf of Doctors Manitoba jbrown@doctorsmanitoba.ca ***Feedback Letter 6 attached***
3 Kali Braun and Kirsten Luomala, Canadian Association of Physician Assistants www.capa-acam.ca ***Feedback Letter 7 attached***
Public Member
1 We need specialists in Manitoba that can help address the physician shortage crisis here in Canada. It's clearly indicated that American certification is accredited and well known to provide adequate training, knowledge and safety. Doctors getting educated under the American Board, from Canada, especially when they are manitoba born and raised, should be allowed to practice without any contracts that will lock them to be working in the USA on a long term basis.
1 2 3 **1.** I do not see the difference between a trained physician in the US and in Canada. They both are medical professional that have gone through rigorous process and steps to obtain their license. **2.** We aren't the first province to do this so we have the opportunity to learn from other provinces and find the best way to implement this. **3.** We need trained physicians to help with the medical professional shortage we have in Manitoba.
2 I believe the amendment is important and should be implemented immediately. The current requirement of 3 years in the last 5 years is not sustainable and prevents good doctors from applying from the pra. There is no risk to manitobian with the amendment, however continuing the 3 years in 5 years causes more patients harm. I implore the college to make this necessary change to 6 months in the last 3 years in regards to the PRA program in Manitoba to ensure patients safety. Thank you
2 I strongly believe it is in the best interest of maniobians to adjust the recency of PRA to 6 months in the last 3 years in patients interest. Manitoba is the only province requiring 3 years in the last 5 years and this does not work in our interest. I am a Manitobian and support the needed change to 6 months in 3 years immediately.
1 I am writing regarding the Regulation Amendments to enhance pathways for international physicians. Changing the regulation allows for an increase specialists in MB and this helps address the physician shortage crisis which we face here everyday. Women's health is deeply impacted by lack of physicians, especially specialists and it's something that I hope to advocate for. The training provided to physicians in the US should be considerate adequate and equivalent to the Canadian requirement and by

making this amendment, more women (and men and children) will be able to receive the necessary care, hopefully only having to wait a few weeks instead of months or years.
1 I am writing in support of the proposed changes to recognize American-trained and American Board Certified physicians as equivalent to Canadian-trained specialists for the purpose of licensure in Manitoba. Given the physician shortage in our province, especially in specialized care, this change would be a meaningful step toward increasing access to healthcare for Manitobans. U.S. Board Certification reflects rigorous training and high standards of safety and competence that should be considered sufficient for practice here. I also encourage CPSM to reconsider the requirement for applicants to hold an active U.S. license at the time of application. This condition may unfairly disadvantage new graduates who hope to return to Canada directly but face visa and contract hurdles in the U.S. Such a requirement could prevent well-trained, qualified physicians from contributing to the Manitoba healthcare system at a time when they are most needed. Thank you for your time and consideration.
1 Why are we restricting any Doctors that are fully Licensed in the USA to Mb. This is ridiculous. The Un SA Dr and just as qualified as our Canadian Doctors if not more So. 1. We need specialists in MB and this helps address the physician shortage crisis 2. The American certification is felt to be/indicate adequate training, knowledge, safety, etc... 3.If the Doctors/applicant have an active license to practice in the USA when they apply to MB for a license. People who are graduating to become a Doctors and then hoping to immediately come back to Canada may get stumped by this requirement is truly crazy. 4. Why should a Doctors. who is necessarily able to get a state board license without a visa/signed job contract sponsored by a hospital in the USA, which the locks a person in for a few years of work. Makes no sense to me when we have a shortage of Doctors. already. 5.And any other certified docs post grad to be able to come to MB without getting locked into a contract in the USA first it stupid. This is something need to be changed in Manitoba that this as an unnecessary requirement and hopefully you can too. 6. We should feel lucky and privilege that Doctors who are Licensed or graduate in the medical field from The USA, even want to come to Manitoba to practice medicine or be a Doctors here for us, considering the shortage we have in our medical field. 7. Hopefully you take a deep look into rejecting USA Doctors for coming to Manitoba over these ridiculous regulations.
1 We have a physician shortage crisis and we need more specialists in Manitoba. Please allow American Board Certified Doctors to be licensed in Manitoba. American certification should be adequate training for North America (USA and Canada). Also, certified Doctors post grad should be able to come to Manitoba without getting locked into a contract in the USA first. Lets get more specialists in Manitoba.
1 2 3 To share my opinion, in reality healthcare system in Manitoba is need of Physicians to support the health care needs of Manitobans. If the support can not be obtain from the locals it is not a bad idea to use other resource such as International Physicians who are Canadian residents and permanent residents. Making it not too difficult to obtain a Physician license will encourage more international physician to pursue their medical license in Manitoba.

As for clinical assistants , from my knowledge they already passed a few exams to be able to hold such designation in Manitoba. They deserve to use Dr. (Clinical asst) title . They play an important part in delivering health care support. And I am positive they want to hold a medical license. The proposed amendment to enhance pathway for International Physicians will lead to a better turn out in having additional Physicians that can see the Manitoba population on timely manner. These will for sure improve the wait time , and will lead to a better health care system. I do trust the Medical governing body to over see the safety of the people of Manitoba.
2 It is important to change the recency for PRA to 6 months in the last 3 years because a) Manitoba is the only province that requires 3 years in the last 5 years 2) Limits the number of good doctors that can apply 3) The currency 3 years negatively will affect patient care of Manitobans. The amendment removes unnecessary bureaucracy for highly qualified doctors The changes does not negatively impact patients' health but positively improve patients' health Current requirement of 3 years in grossly inappropriate and should be changed immediately. Thank you
1 2 3 I am writing to share my thoughts on three recent CPSM proposals. Firstly, regarding the proposal to allow American board-certified family physicians to practice in Manitoba without undergoing significant additional training, examination and assessment. While I agree it is time consuming and costly, I believe these exams/training/assessment remain essential. The Canadian healthcare system differs significantly from that of the U.S. in areas such as care delivery models, guidelines, and patient expectations. They ensure physicians understand the Canadian healthcare context, safeguarding patient safety and care quality. Secondly, concerning the amendment to reduce barriers for provisional registration—lowering the requirement to 960 hours of clinical experience in the last 3 years—I recommend maintaining the existing prerequisite of one year of postgraduate training and at least three years of practice in family medicine within the preceding five year period.. This standard better ensures clinical readiness and increases the pool of well-qualified physicians, helping address Manitoba's healthcare workforce shortage more sustainably. I appreciate CPSM efforts to improve access to care and respectfully suggest that maintaining strong, proven standards will support both system integrity and patient trust. Thirdly I support the CPSM's proposal to address Clinical Assistants as "Dr" given their medical degrees. However, to avoid confusion with fully licensed physicians, using the designation "Dr. (Cl.A)"—acknowledging their qualifications while clearly distinguishing their role from independently practicing doctors in the Canadian healthcare system is a perfect decision.
3 This proposal will be a big help for healh industry especially if a person like my niece **** ***** who is currently practicing as a clinical assistant at health science centre. Her dedication to the field of medicine is worth commendable. As far as i know way back in ******* she is a family medicine / general practioner. Her services and vast knowledge on the choosen field was highly recognize. Perhaps those like her who have exerted time and effort should be given that kind of opportunity to use the title "Dr". In conjuction with "Cl."A. Thanks!

1 2 3 **Feedback Letter 8 attached**
2 Unnecessary impediments should be removed to allow qualified medical professionals to practice their profession in Manitoba which will help patients considering that our country needs more doctors to help the citizenry. International Medical graduates who have license from a medical jurisdiction should therefore be allowed to practice their profession as medical doctors in Canada since they also undergo supervised practice here in our country.

[redacted]

[redacted]

Drs. Office [redacted]

Office Fax [redacted]

[redacted]

College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg
Manitoba
R3J 3T7

18th May 2025

Submission to CPSM

Thank you for the opportunity to comment on the designation of Dr.

The Dr. designation was and still should be a university achievement. It has been downgraded over the years, to the confusion of the public, so that Dr. does not have the same meaning re competence that it used to have.

To increase the number of Drs. because government wishes to state that everyone has a doctor, is misleading, and is neither necessary nor rational.

Other jurisdictions may have accepted this change, but that is no reason to confuse the public, who expect a certain level of competence in someone designated a Dr.

Respectfully submitted:

[redacted]

LETTER 2

[redacted]

Drs. Office [redacted]

Office Fax [redacted]

[redacted]

College of Physicians & Surgeons of Manitoba
1000-1661 Portage Avenue
Winnipeg
Manitoba
R3J 3T7

18th May 2025

Submission to CPSM

Thank you for your letter of April 17th 2025 requesting feedback on regulation amendments to enhance pathways for International Physicians.

I believe it should be clear to everyone that we have a severe shortage of healthcare workers in Canada and especially in Manitoba. In trying to rectify the situation I believe we should be greatly enlarging our Medical School or developing an additional Medical School along with greatly enlarging the Nursing Colleges and Colleges for Lab workers. It seems grossly unfair that we rely on other countries to educate their citizens in the medical fields, then once they are qualified they are lost to Canada because we advertise and offer them money to come to here instead.
The solution of training more people ourselves is the long term approach but surely this must be initiated!

With regard to the immediate proposals:

1. Removing restrictions on American Board Certified physicians.
   I am in absolute agreement with this. I believe this should have been done a long time ago.

2. Reducing barriers for Provisional Registration of Family Registrants.
   I am in agreement with this except I would suggest that the Registrant be subject to a simple review in some way at the end of 3 years, a check to see if any complaints have been made, a simple audit of 5 random files etc

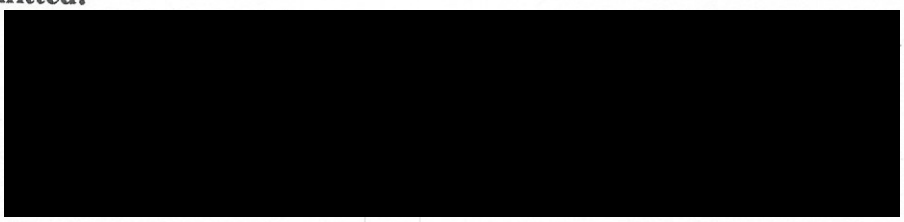
3. Allowing Clinical Assistants to use the title "Dr." or "Doctor".
   Why is this necessary? Surely if a person is trained at a respected Medical School outside of Canada and has the proof they have graduated and been able to pass the qualifying exam here, then they should automatically be in this category, and be regulated by the College of Physicians and Surgeons just like other doctors.
   If the Medical School has not reached the equivalent status of ours and individual does not wish or cannot afford to do the full upgrading, I presume they can take the Physician's Assistant course. If this is the case, then I think we could be creating some very real issues if they are allowed to call themselves "Doctor" in Manitoba:
   a) More individuals will choose this route rather than spend more time and money on a more complete education.

b) Some countries may develop a number of low standard Medical Schools who would entice individuals to spend money to get in easily to Medical School, when they have been unable to qualify over here. If we start discriminating against certain Medical Schools and countries, we may be accused of racism.
c) Although Chiropractors and Optometrists are allowed to use this title, I find that many of the patients do not understand the difference each has received in their medical education, and I have to give an explanation. In the case of Physician Assistant now using the title "Doctor" I feel is misleading the public.
d) Will the people who qualify as Physician Assistants, without having done a medical degree in another country, also want to use this title. (I believe some do unofficially). Many patients have told me they actually prefer to see the Physician Assistant as they have found them easier to talk to than the doctor!

4. I have a suggestion to help with the present health care crisis regarding quick access to physicians:
Could we allow those doctors ***and who wish to*** ,who are registered with the Manitoba College of Physicians & Surgeons, respond to a call from their patient in Manitoba and be paid for their time, when they themselves are still in Canada but not in Manitoba for some reason. Not every physician would want to do this, but this could be personal choice. There are many situations when talking directly to your own physician would save time, save the Province financially and provide more efficient health care.

In conclusion, I believe this is an extremely difficult problem, which has been needing a solution for many years and we must develop some solutions as soon as possible. Having said that I believe it is essential that we do not mislead the public by manipulating words and we must ensure our high standards are maintained.

Respectfully submitted:



LETTER 3

Dear & Highly Respected Registrar;

Kindly find below my feedback in **Red.** I will be so happy to answer any of your questions

Hope you find any of it helpful. Thank you for your trust & great efforts.

-

[redacted]

REMINDER: Submit your feedback for the following regulation amendments:

As kindly received in the email from respected Registrar:

These amendments will expand opportunities without compromising quality or safety for those eligible to practice medicine in Manitoba.

Public Consultation: Regulation Amendments to enhance pathways for international physicians

April 17, 2025|

News Public Consultations Registration

CPSM requests feedback from the public, registrants, regulated health professions, and other stakeholders regarding three regulation amendments to better support and attract qualified and

competent internationally trained physicians, ensuring a fair and efficient pathway for their integration into the Manitoba healthcare system.

1. **Removing restrictions that delayed American Board-Certified physicians becoming fully licenced registrants**;
2. **Reducing barriers for Provisional Registration of Family Registrants**;
3. **Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction**

These amendments will expand opportunities without compromising quality or safety for those eligible to practice medicine in Manitoba.

Background

CPSM protects the public by ensuring registrants have the proper qualifications to practice medicine.

In early 2025, CPSM raised concerns and made recommendations to the Manitoba Government about amending certain provisions of the *CPSM General Regulation* M.R. 163/2018 that are unnecessarily restrictive and may be limiting qualified professionals applying to practice medicine in Manitoba.

As is outlined below, the proposed changes will increase the number of qualified professionals eligible to apply to practice medicine without compromising public safety.

Amendments to the CPSM General Regulation require a 30-day public consultation.

Proposed Changes

1. American Board-Certified Physicians

The first proposed change will allow all physicians from the United States to apply directly for full (practicing) class if they meet the following requirements:

- have successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education,
- hold certification from a Member Board of the American Board of Medical Specialists (ABMS), and
- have an independent or full licence to practice with a U.S. state medical board

Currently, these individuals must first apply for provisional registration, which places limitations on their ability to practice medicine (such as requiring supervisors, assessments, and practice location restrictions). These restrictions are costly and time-consuming. They place a significant disincentive on qualified physicians applying to practice medicine in Manitoba.

Rationale

The Canadian Free Trade Agreement (CFTA) entitles physicians who hold an independent practice licence in another Canadian province or territory to apply as a Regulated Member Full Practising class without having to undergo significant additional training, examination or assessment. Accordingly, what is occurring in other provinces is relevant to Manitoba:

- Medical Regulatory Authorities in British Columbia, Saskatchewan, New Brunswick, Prince Edward Island, and Nova Scotia have introduced similar provisions. Quebec has them for family medicine.
- In Ontario, the College of Physicians and Surgeons of Ontario has established alternative pathways for U.S.-trained physicians. Specifically, physicians who have completed an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency and hold certification from an ABMS member board may be eligible for a restricted certificate of registration to practice independently within their scope. This is essentially equivalent to full licensure in Manitoba and has been recognized by CPSM under the CFTA.
- In Alberta, the College of Physicians & Surgeons of Alberta (CPSA) initiated a five-year pilot project as of January 2023, streamlining the Practice Readiness Assessment process for internationally trained physicians from approved jurisdictions, including those with certification from the American Board of Medical Specialties (ABMS) This initiative aims to expedite the integration of qualified U.S.-trained physicians into Alberta's healthcare system. The pilot project waives the first 3-month PRA requirement. Internationally trained physicians go directly to their identified communities and begin practising independently for three years while completing their Supervised Practice Assessment. Successful practice during those three years (as determined by CPSA) allows transfer to the general register without the requirement of Canadian certification in the discipline of practice.
- Physicians who have completed accredited postgraduate training in the United States and hold certification from an ABMS member board may be eligible for provisional licensure in Newfoundland and Labrador.

While specific studies directly comparing the safety and competence of American Board-certified physicians practicing in Canada to their Canadian-trained counterparts are limited, it is generally accepted that, as a category, these physicians are competent and safe practitioners.

CPSM's approach to ensuring safe practice is to address individual practitioners rather than imposing blanket requirements for all as a means of ensuring these individual physicians are practicing medicine safely. They will, within the first year of practice in Manitoba, be required to participate in a Quality Assurance audit process.

We also recognize there are challenges for all internationally trained registrants who have recently come to Manitoba in adjusting to the practice of medicine in the province. As such, by the end of 2025, CPSM plans on implementing an orientation program for all International Trained Physicians who are new to the Canadian or Manitoba practice

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2. Reducing barriers for Provisional Registration of Family Registrants

Provisional registration is granted to physicians who meet some but not all requirements for full practicing registration. A registrant who is provisionally registered will be entitled to practice medicine with certain limits and conditions at a geographic location approved by the Minister of Health. Conditions include the need for supervision and practice audits. A provisional registrant will have five years to attain all the requirements for full registration.

The *CPSM General Regulation* lists the requirements an individual must have to apply for provisional registration. There are multiple pathways for registration in the provisional (family practice-limited) class, one of which is that the applicant has completed at least one year of post-graduate clinical training in family medicine and has **"at least three years of practice experience in family medicine in the preceding five-year period."** Candidates who follow this route to provisional registration will typically require a Workplace-Based Assessment (i.e., a Practice Readiness Assessment through the Manitoba Faculty's International Medical Graduate (IMG) Program).

Rationale

The prerequisite of having at least three years of practice in family medicine in the preceding five-year period to apply for provisional registration was separately reviewed by the Manitoba Faculty and CPSM's Board of Assessors (which was established to consider complex registration applications). They recommended the prerequisite be amended to ***"a total of at least 960 hours of direct patient clinical practice experience in family medicine in the preceding 36 months."*** This is approximately equivalent to six (6) months of practice in the past three years.

CPSM and the Manitoba Faculty believe that these changes will increase the number of individuals who meet the registration requirement and Practice Ready Assessment eligibility, and at the same time improve the likelihood that they will successfully complete the requirements of provisional registration.

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My Feedback is-In Red- On the Above 2 Topics i.e

1. **Removing restrictions that delayed American Board-Certified physicians becoming fully licenced registrants**;
2. **Reducing barriers for Provisional Registration of Family Registrants**;

    1. **I do highly recommend and support all strategies like the above to facilitate and accelerate the attachment and take off of all designated physicians to get fully licensed registrants to enrich our medical manpower.**
    2. **I believe that reducing the minimum prerequisites to ?6 Months is quite helpful and it would be great to consider.**
    3. **However, I kindly suggest that this & Other facilitating prerequisites are applied to boost the numbers of Clinical Assistants who are applying for same. Examples/Suggestions:**
        - **Allow clinical assistants who have been in family medicine practice in Manitoba (As Cl.As) for at least 24 months-or 36 months block of recent practice (No Later Than 2**

years from date of Application) to Apply to the MLPIMG program if they Have NAC-OSCE or MCC-QE2 & Also allow to apply to the PRA if they have both (NAC-OSCE + MCC-QE1) or (MCC-QE1 +2)

- Allow clinical assistants who have been in family medicine practice in Manitoba (As Cl.As) for at 24 months-or 36 months block of recent practice (No Later Than 2 years from date of Application) to Apply to the MLPIMG program if they DON'T HAVE any post graduate Family Medicine Independent Practice or if they …… HAVE NON FAMILY MEDICINE post graduate independent practice or residency or internships even like in Surgery,Obs/Gyn ,Medicine .Since they have already been practicing family medicine in Manitoba for 2-3 years. Of course Provided they Have Either NAC OSCE or MCC-QE2
- Accepting Clinical Assistant Assessment Exam equally as NAC-OSCE exam only if a Prove of a minimum of 2-3 years ,current Family Medicine Practice are provided. In other words,
    1. CA who have NAC OSCE + Minimum 2 Years Current Family Medicine Practice will meet criteria for applying to the MLPIMG Program Also
    2. CA who have Doesn't have NAC OSCE but Has Clinical Assistant Assessment + Minimum 2 Years Current Family Medicine Practice will meet criteria for applying to the MLPIMG Program Also
    3. (1+2) are regardless of whether Cl.Assistant had any Post graduate Internship or residency of any type or not at all . Since his currency of practice is met by his current minimum of 2-3 years practice in family medicine & his exam requirement is met by his provided PASS in Clinical Assistant Assessment (i.e He doesn't need to provide prove of any post graduate practice whether independent or as training to be accepted for MLPIMG when he already has the required (Minimum 2-3 years family medicine CA Practice + Clinical Assistant Assessment)
    4. In Other words: Clinical Assistant Assessment Exam + Minimum 2-3 Years Block CA Recent Practice in Family Medicine = Exemption from NAC OSCE if the CA is planning to join the Family Medicine MLPIMG Program ONLY. This is not true criteria to get the LMCC but can be discussed or considered ?
- Accepting IMGs who are Either fresh medical graduates or Who have Prove of recent Family Medicine or General Practice no later than 6-12 Months from their last day formal practice to Join the Manpower of Medical Practice in Manitoba Provided that :
    1. They must prove a good verbal & written English
    2. Must sign a contract to work as CA in certain rural area for at least 2-3 years of block practice with very clear Penalty like:
        1. Money to be paid back if breaking the contract
        2. Restriction to get other licensure & registration or joining (CaRMS) in Manitoba before the period of 2-3 years is over.
    3. Recent Practice & Being a Fresh Medical Graduate with very good English gives access to medical practice under supervision as Clinical Assistant in Family Medicine under supervision in Rural Areas ONLY if a Contract was signed to stay for 2-3 Years (3 years better) but with another condition which is that this

CA must Pass his NAC OSCE if planning to have LMCC and or If planning to join the MLPIMG or PRA Family Medicine.

This is the End of My Feedback on Topics 1 & 2

Here is my Feedback On the Last or 3rd Topic:

3. **Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction**

I SUPPORT & FULLY AGREE :

CA.s can never ever & will never ever or have never ever Sign without writing / For Dr.X or Y . & no order whether a prescription or Dx requision will ever be accepted or processed by having the name of the CA fully signed i.e CA-Name/ For Dr.X or Y . this is 100 % is being done and applied all times without exclusion at all & CA.s Never ever use the term "Dr. or Doctor " when they sign …..

However, in Fast Practice and very busy practice, verbally ,in our communications, we face unlimited encounters that we may use or may have used and we are so happy that this topic is brought into discussion.

In my11 years experience as a Clinical Assistant(5Y-Acute Care & 6Y-Family Medeicine) , I ,100% without exclusion introduced myself as Cl.Assistant verbally & sign as such. But I was never been able to control how people call me.

Many colleagues, patients & community (more than 98%) addressed me as a Doctor & I wasted lots of (Inconvenient times) correcting people and explaining to people the idea and role as well as the title Clinical Assistant and role limitations.People insist on calling us as Doctors Simply as we are doing exactly the same role of the doctors and often I was doing better than or more than what the real doctor is doing . So having said that Our role is a Mirror Copy of the Supervising Physician.It will be great and quite fair and descent as well as rewarding to be called as Dr. but of course with either an introductory statement or prefix statement like: [redacted], Our /My Clinical Assistant or Our /My Clinical Assistant , [redacted]……

This will simply fix,consolidate and confirm the reality and will ease our life as clinical assistants and relief lots of stressors and anxiety at our workplace and lots of embarrassing and inconvenient encounters we are facing as clinical assistants from our workplace colleagues & staff examples :

- **I had to defend myself unlimited times when (either toxic or new managers)people complain to my supervising physician that they heard ziad introducing himself as Dr . or People address me as Dr or as if [redacted] is available to book with etc**
- **I have never ever introduced myself as Dr. unless in very specific situations**
- **With elderly seniors who have either MCI or advancing Memory loss or delirium due to illness or drugs and his tory taking or handling such valued and wonderful clients and talking to them needs to select best terminology to attain best understanding and cooperation and getting best history. Yes I did introduce myself rarely to such lovely clients as Doctor especially when they have Hearing loss and concomitant vision weakness etc.. I found that ,telling the client that I am the "Doctor"**

and his family telling him/her that this is the -Dr- makes practice and handling quite easy and facilitated.Although family are well aware that I do same role of the Supervising Physician but Under Supervision only.

- **The same applies to introducing myself to an anxious ,first time visiting baby ,toddler or a child.**
- **Unfortunately, People used this as an easy point to complain against me and I had very hard ,even insulting or humiliating times with my supervising physician as I was accused that I am violating CPSM Directions instead of being handled maturely and in a professional way and or instead of being offered a little -Thank you- for taking great care of our seniors, MCI,Hearing loss clients and kids. And finding me and other CA.s solutions and getting opinion from CPSM.**
- **I am so happy & appreciate that this topic is being put on the table for discussion and I do highly appreciate if it will be adopted and used in practice.**
- **I kindly suggest that CPSM recommend certain examples of how the Name Tag is shaped .I think that CPSM Can provide us a List of max 3 examples or a clear general Criteria of how & What a Professional Name Tag of a Clinical Assistant may contain or looks like etc you can try this game here 😊**

- **https://www.zazzle.ca/gold_medical_professional_caduceus_blue_name_tag-256837267780238830?dz=ba9feb4e-2aca-4340-b567-053fa9495929**

END OF MY FEEDBACK OF CA " Dr" Question.

Clinical Assistants are CPSM registrants who have a critical role in the delivery of health care in Manitoba. Many have a medical degree from a nationally approved faculty of medicine in another

jurisdiction or, in some cases, Canada. However, those with medical degrees are not entitled to use the title “Dr.” or “Doctor” in the practice of medicine, even though they were previously able to use the title while in residency in Canada, or as a practicing physician in another country.

Other health care professionals who may use the “*Dr.*” or “*doctor*” title in Manitoba, in conjunction with identifying their profession include optometrists, dentists, chiropractors, and naturopaths.

Rationale

The proposed change would favorably enhance the Manitoba practice environment by recognizing this class of professionals’ credentials through appropriate dignity and respect. Associate Physicians and Clinical Assistants can use the title in other jurisdictions, including British Columbia, Alberta, and Saskatchewan.

It must, however, be clear that use of the title is in conjunction with the Clinical Assistant title. This is to avoid confusion that they are licensed and practicing as a physician or surgeon. An example of how this will be used is “Dr. Smith (Clinical Assistant).”

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Request for feedback

CPSM seeks your thoughts and perspectives on these three proposed changes to the *CPSM General Regulation*.

Questions to consider:

Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba?

Do these changes negatively impact patient safety?

Or are the current regulatory requirements appropriate?

View the proposed regulatory changes

View a “side by side” comparison of the current regulation to the proposed changes

How to submit your feedback

1. Review the proposed regulatory changes and details for each proposed change above.

2. Submit your comments in writing by email to: CPSMconsultation@cpsm.mb.ca

The deadline for feedback is 11:59 p.m. on May 25.

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University of Manitoba | Rady Faculty of Health Sciences

Max Rady College of Medicine
International Medical Graduate Program
P219 – 770 Bannatyne Avenue
Winnipeg, Manitoba R3E 0W2
Phone: 204-975-7757
Fax: 204-272-3090

February 13, 2025

Dr. Ainslie Mihalchuk
Registrar,
College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Avenue
Winnipeg, MB R3J 3T7

Dear Dr. Mihalchuk,

We would like to propose a change in the criteria for application of provisional (family practice-limited) registration at the CPSM level in particular 3.19 (1) b.(iv) "has had a total of at least three years practice experience in family medicine in the preceding five-year period."

We would like to recommend a change to "a total of at least 960 hours of direct patient clinical practice experience in family medicine in the preceding 36 months, for recency of practice; and a total of 2 years of independent practice since post grad training."

There is a paucity of evidence regarding the association between the recency of practice and the success rate of a practice ready assessment. That being said, based on the current landscape and expert opinion across Canada the updated requirement would be moving toward a greater specificity akin to other provinces. Currently, Manitoba is 1 of 9 provinces (in Canada) that conducts practice ready assessments, and it has the most stringent recency of practice criteria of 3 out of most recent 5 years. The most common requirement (3 provinces) is 960 hours within the last 3 years, and some others are requiring as little as 450 hours within the last 3 years.

For the independent practice requirement, 2 provinces require only 1 year, and 3 provinces require 2 years, and MB with 2 other provinces require 3 years.

By requiring 3 out of last 5 years in recency practice, Manitoba has and will continue to overlook the majority of candidates, who would otherwise be qualified as candidates for other provinces' PRA programs. Attached is a summary of the PRA programs across Canada which was provided by the Medical Council of Canada Research Consortium.

Three years within in the preceding five-year period leaves a sense of ambiguity given it does not specify full time or part time work. It also does not take into account time away from practice throughout the year. Requiring a minimum number of hours would help clarify these situations. We do understand it may be difficult to confirm exact hours however this is more in line with current expectations in other provinces.

The inclusion of direct patient clinical practice also provides a framework that supports clinical practice rather than administrative thus improving outcomes in the PRA as well as success in future clinical practice.

Should the proposed change be approved, all successful applicants, will still undergo 3 months of intense assessment to determine their competencies in delivering safe and effective medical care. Should they be successful in their assessment, all of them will practice with both a practice supervisor and enrolled in a structured mentorship program for a minimum of 1 year to ensure their practice is safe and continue to meet the standards of care.

We want Manitoba to be an attractive option for potential international medical graduates and consider the PRA program and having similar recommendations and processes (with other provinces) may help achieve this goal.

Sincerely,

Holly Hamilton

Holly Hamilton, MD, CCFP, FCFP
Director,
PRA MB-FP Program

College of Pharmacists of Manitoba

200 Tache Avenue, Winnipeg, Manitoba R2H 1A7
Phone (204) 233-1411 | Fax: (204) 237-3468
E-mail: info@cphm.ca | Website: www.cphm.ca

May 22, 2025

The College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg, MB R3J 3Y7
Via email: CPSMconsultation@cpsm.mb.ca

Dear College of Physicians and Surgeons of Manitoba (CPSM) Colleagues,

Thank you for the opportunity to provide feedback on CPSM's proposed regulations to streamline licensure for internationally trained physicians. The College of Pharmacists of Manitoba (CPhM) is also working to modernize licensure processes, and we're encouraged to see CPSM taking steps to make Manitoba a more attractive destination for qualified professionals.

CPhM has reviewed the consultation questions and supports the proposed amendments. U.S.-trained physicians who have completed ACGME-accredited residencies, hold ABMS certification, and are fully licensed in a U.S. jurisdiction have already met high standards. Requiring provisional registration with additional conditions may unnecessarily delay their ability to contribute to Manitoba's healthcare system. Aligning Manitoba's approach with provinces like British Columbia, Saskatchewan, and New Brunswick supports national consistency and may enhance physician recruitment and retention in the province.

Shifting the focus to individualized assessment—rather than applying broad, uniform registration and licensing restrictions—is in line with current best practices for risk-based regulation. The proposed Quality Assurance audit in the first year of practice is a valuable tool to ensure public safety while allowing qualified individuals to begin contributing to Manitoba's healthcare system.

CPhM also supports the proposed change to the family practice experience requirement. Replacing the three-year requirement with 960 hours of direct patient care over the past 36 months offers a more relevant and practical measure of recent clinical experience and competence. CPhM would encourage that prerequisite practice experience required be aligned with other provinces for similar classes of registrants, to support regulatory consistency across the country.

Once again, thank you for the opportunity to provide feedback. Should you have any questions or concerns regarding the feedback provided, please feel welcome to reach out.

Kind Regards,
Sent on behalf-of CPhM

Meret Shaker, B.Sc., B.Sc.(Pharm.)
Practice Consultant – Policy and Legislation

Doctors Manitoba
20 Desjardins Drive
Winnipeg, Manitoba
R3X 0E8 Canada

T: 204 985-5888
T: 1 888 322-4242 (toll free)
F: 204 985-5844

May 23, 2025

The College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Ave
Winnipeg, MB R3J 3T7
CPSMconsultation@cpsm.mb.ca

To Whom it may concern:

Re: Regulation Amendments to Enhance Pathways for International Physicians

Thank you for providing Doctors Manitoba with the opportunity to provide comments on the proposed amendments to the CPSM General Regulation (the "Regulation"), to enhance pathways for internationally trained physicians.

We appreciate the efforts of CPSM to address this vital issue. Attracting qualified internationally trained physicians to practice in Manitoba is an important part of addressing the physician shortage in Manitoba.

We amplified the CPSM's consultation message in two separate newsletters to our mutual members. We provided the link to the consultation documents, and invited our members to copy us with their submission to the CPSM. As usual, we also offered our members the opportunity to send their comments to us directly if they did not want to communicate directly with the CPSM.

1. Full licence for US physicians

The proposed amendments to the Regulation would allow physicians from the United States to apply directly for a full licence, as long as they have completed a recognized residency program, hold certification from a Member Board of the American Board of Medical Specialists, and have a full licence to practice with a U.S. state medical board.

Doctors Manitoba offers our unqualified support for this change. We do not believe that this quicker pathway to licensure presents any increased risk to Manitobans, as the CPSM's plan to follow up on the new physicians by way of a timely practice audit. Further, we are satisfied that a large majority of our members are supportive.

As the CPSM has confirmed in the consultation documents, a similar change has already been made in several provinces. This change will remove a substantial barrier to attracting U.S. trained physicians to Manitoba.

Doctors Manitoba has found itself in the discussions about pathways for physicians to practice in Manitoba. Although Doctors Manitoba neither recruits nor engages physicians, we have been contacted by health authorities, private clinics, and U.S. physicians wanting advice and assistance on immigration and licencing issues.

We have dedicated considerable staff time to responding to requests and assisting interested physicians. We encourage facilities and physicians to speak with the new Health Care Recruitment and Retention Office (HCRRO) and expect we will continue to do so. We have advised some U.S physicians considering coming to Manitoba of this consultation, and they are uniformly grateful that CPSM is considering this change.

We believe that granting full licences to U.S. physicians who have successfully attained Board certification has a low risk to Manitoba patients. We understand that the CPSM will conduct a Quality Assurance audit in these physicians' first year of practice in Manitoba to ensure their practice meets the Manitoba standard. Doctors Manitoba is happy to play a role in sharing the CPSM's information about the Quality Assurance process. We expect we might be contacted by new physicians about the audit and anticipate playing a non-adversarial role in these physicians in cooperating with and replying to these audits.

2. Reduce threshold of recent practice time for other IMG physicians

The proposed amendments to the Regulations would provide a modest loosening of an eligibility rule for other internationally trained physicians.

At present, an internationally trained family physician applying for a provisional licence, usually requiring a Practice Ready Assessment (PRA), must have practiced elsewhere for *three* of the previous *five* years.

The amendments would reduce this requirement to 960 hours of practice (about *six months*) in the previous *three* years. This is expected to expand the pool of potential applicants.

Doctors Manitoba supports this positive step. However, as we will set out in more detail below, we do have some concerns about the current capacity of Manitoba to manage an increased number of PRA requests.

Members who have reached out to us are generally, although not uniformly, supportive of this proposed change. We did hear from some members concerned with the quality of physicians who have successfully completed the PRA program. We expect the CPSM – subject to the pressures we note below – will continue to improve and enhance the PRA program as part of the ongoing mandate to protect patient safety.

The intended success of this proposed change will put more pressure on the PRA program. The PRA currently struggles to provide assessments in a timely way, and additional resources will be required to have more successful PRA candidates.

Doctors Manitoba is willing to advocate, preferably alongside the CPSM, for greater government investment in the PRA program. Government must recognize that the PRA program is a timely and cost-effective way to prepare internationally trained physicians for practice in Manitoba. There must be sufficient support from government for the CPSM and the University of Manitoba, which together bear the responsibility for much of the work in screening candidates, matching candidates with supervising physicians, and training supervising physicians to provide meaningful direction and assessment. Government must also support reasonable incentives for physicians to invest their time to supervise PRA candidates.

We believe the CPSM is doing the right thing by increasing the pool of potential PRA candidates. However, we want to make sure that Manitoba gains the maximum benefit from this proposed change.

3. "Doctor" title for Clinical Assistants

The Regulation would allow Clinical Assistants holding a recognized medical degree to be able to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "CI.A."

This proposed change came as a surprise to Doctors Manitoba.

The CPSM says this would “favorably enhance the Manitoba practice environment”, and follow similar changes in B.C., Alberta, and Saskatchewan. Although it is not expressly set out in the consultation documents, we understand the CPSM’s position that this is a recruitment and retention issue. We understand CPSM’s position that without this change, we will lose potential Clinical Assistants (who are ultimately a source of physicians) to these other provinces.

Several members have reached out to us. While some reactions have been largely negative, and some members have raised serious concerns, we also received a number of constructive comments. There are a number of themes raised which lead us to the conclusion that our members could be moved to be supportive of this change, but more work is needed before this change should go into effect.

First, the title of “Doctor” continues to carry a lot of influence and respect, something that Doctors Manitoba and CPSM have an interest in preserving. Our mutual members believe strongly that the use of this title carries with it not only prestige, but a great measure of responsibility. Our members are aware that it requires their words and actions to be carefully measured to avoid bringing the profession into disrepute, and to ensure that any statement which run contrary to the prevailing medical standard must be so identified to the patient and, where necessary, to the public at large.

Some of our members have reminded us that certain other health care professions granted the use of the title “Doctor” have exercised far less control and/or interest in the words and actions of their members. We don’t have to look any further back than the COVID epidemic to find the example of certain chiropractors who took every opportunity to attack vaccination and other public health measures intended to protect Manitobans and Canadians, apparently without any intervention by their regulator. We intervened not long ago with the CPSM when a lapsed optometrist calling himself “Doctor” (without qualification) promoted his expertise at treating addictions on the radio. Even a “Doctor” of psychology, in trouble with his regulatory body, recently came to Winnipeg to tell us about what it’s like to wrestle with God. Our members expressed concerns that the media may not appreciate the difference between a medical doctor and others who call themselves “doctors”. Social media creators may not appreciate the difference either or, even worse, will purposely promote ridiculous statements by non-physician “doctors” to spread misinformation.

While these may be extreme examples, they do highlight the weight given to someone who is permitted to use the word “Doctor” as their title. The qualifiers are often ignored or misunderstood, especially by those who wish to discredit medicine and science and their gullible followers.

We do note that Clinical Assistants are, and will remain, under the direct regulatory authority of the CPSM, and accordingly the CPSM has recourse should they act inappropriately.

Some members also expressed concern about confusion by patents and their families respecting the role of Clinical Assistants, the nature of their education and training, and their scope of practice.

At the same time, some members noted that medical residents are already able to use the title “Doctor”.

We agree that there may be some confusion in practice settings, as patients and their families may not make the distinction between physicians and Clinical Assistants. At the same time, patients may be frustrated by some limitations on the practice of Clinical Assistants. We believe this requires efforts by the CPSM to educate the public.

We recommend that the CPSM prepare easily referenced and easily understood materials to allow the public to understand the training and scope of practice of Clinical Assistants, and the fact that they may be prepared to commit to further training in Manitoba to become physicians.

We believe this proposed change is complex. While we appreciate the CPSM’s view of the recruitment and retention benefits, we think more work needs to be done to prepare the public.

Accordingly, we respectfully ask that this proposed change be deferred to allow for more discussions and dialogue, to prepare of a communications and education plan by CPSM for members and the public generally. This will ensure a broader understanding of the respective roles of physicians, residents, Physician Assistants, and Clinical Assistants, including why only some are able to use the title “Doctor” in clinical settings. A plan to promote and explain the pathway of Clinical Assistants to fully licenced physicians would aid in the “social marketing” to our members and the public.

In conclusion, Doctors Manitoba appreciates the CPSM’s efforts to enhance pathways for internationally trained physicians. We look forward to working with the CPSM to smooth the pathways for qualified and appropriate applicants to practice in Manitoba. We will use our voice to support public investments in cost-effective and safe pathways for internationally-trained physicians to be licenced in Manitoba, as an important measure to address the shortage of physicians in Manitoba.

Yours truly,

Andrew Swan

ANDREW SWAN
General Counsel

AS/jb

Canadian Association of Physician Assistants | Association canadienne des adjoints au médecin

23 May 2025

College of Physicians and Surgeons of Manitoba (CPSM)
1000 – 1661 Portage Ave
Winnipeg, MB
R3J 3T7

Via email: CPSMconsultation@cpsm.mb.ca

Subject: Public Consultation: Regulation Amendments to enhance pathways for international physicians

The Canadian Association of Physician Assistants (CAPA) appreciates the opportunity to provide input on the CPSM's Public Consultation: Regulation Amendments to Enhance Pathways for International Physicians.

As a professional association, CAPA typically refrains from commenting on matters related to other regulated health professions or prescribing how members of those professions should be identified. Therefore, CAPA has nothing further to add on the first two elements of the CPSM's proposed changes.

However, in Manitoba, there is significant overlap in the roles and responsibilities of the PA and CA professions. The roles are often used interchangeably in clinical settings, the scopes of practice are closely aligned, and both professions are represented by PCAM. Given this close association, we believe it is important and appropriate to offer our perspective and highlight some important considerations related to patient clarity and understanding on the CPSM's proposed changes to allow Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A". if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.

.../2

Concerns Regarding the Proposal to Allow Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A" if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.

1. Risk of Public Confusion and Misrepresentation

The use of the prefix "Dr.", even with modifiers such as "Clinical Assistant" or "Cl.A.", is widely understood by the public to denote a licensed physician with independent practice rights. CAs, while highly skilled, do not hold independent licensure in Manitoba and work as do PAs, under a contract of supervision/practice description, and cannot practice independently. As such, use of the title "Dr." risks misleading patients, caregivers, and even other health care providers.

2. Inequity between Equivalent Roles

In Manitoba, PAs and CAs work side by side in many departments, fulfilling very similar functions under physician supervision. They are part of the same union and are often treated interchangeably by the health care system. Granting CAs the privilege of using the title Dr. Clinical Assistant or Dr. Cl.A. creates a hierarchy that is not based on function or responsibility. This could risk creating division among professionals who are otherwise interchangeably used and equally valued by the health care system in Manitoba. The title Doctor offers prestige and suggests a hierarchy of skill but is not based on competency and therefore disruptive.

3. Questions Regarding the Purpose and Impact of Title Usage

Further clarity on the rationale for this proposed change would be helpful. Specifically, what issue is this change intended to resolve, and what benefits are anticipated for CAs in being permitted to use the title "Doctor"? Understanding the goals and intended outcomes of this proposal would provide important context for evaluating its impact.

Suite 100, 436 rue MacLaren Street
Ottawa, ON K2P 0M8
admin@capa-acam.ca
877 744 2272
www.capa-acam.ca

4. Physician Abbreviations are already a Source of Public Confusion

Patients are accustomed to seeing multiple designations following a doctor's name—such as CCFP, MCFP, or FRCPC—though most have little understanding of what these abbreviations mean. To a patient, a doctor is simply a physician, and the "MD" is typically assumed. Introducing a designation like "Clinical Assistant" or "Cl.A." after a clinician's name is unlikely to clarify their role; in fact, it may contribute further to patient confusion. If noticed at all, the designation may be misinterpreted as just another professional credential rather than a signal that the individual is not in fact a licensed medical doctor in Canada.

Conclusion

CAPA and our PA members in Manitoba have a great, collaborative working relationship with CAs. They are skilled, essential members of the health care team and PAs value the opportunity to work beside them in patient care. Providing CAs with the title Doctor does nothing to enhance the care that they provide, but instead may be disruptive and create confusion, in the ways we have explained above.

We would encourage the CPSM to explore alternative forms of recognition that honour the prior medical training of IMGs without creating confusion by using the title Dr. (e.g., a post-nominal credential or badge notation that clarifies their background).

Thank you for considering this perspective. We support the recognition and meaningful integration of internationally trained professionals into the health care system, and we believe this can be accomplished in a way that maintains public trust, interprofessional equity, and regulatory clarity.

Kind regards,

Kali Braun, CCPA
Director, Manitoba

Kirsten Luomala, CCPA
President

LETTER 8 0084

[redacted]

May 24, 2025

To Whom it May Concern:

I am responding to the request for feedback on the proposed REGULATION AMENDMENTS TO ENHANCE PATHWAYS FOR INTERNATIONAL PHYSICIANS. My comments are as follows:

American Board-Certified Physicians:

As written, this proposal is predicated on the assumption that American Board-Certified physicians practising in Canada are as safe and competent as their Canadian-trained counterparts while noting that there are limited studies examining this question. While this premise may be “generally accepted” there is no assurance that this is, in fact, generally the case. My contention is that if a physician has actually been trained in the United States for either or both their undergraduate or post-graduate medical education assuming equivalent safety and competence is much more likely to be justified. Therefore, I support this proposal in the case of those physicians who actually graduated from a medical school or residency program in the United States. This would also be the case for physicians who have been practising in the United States but previously studied in a recognized training route jurisdiction and wish to apply for full class licensure. I am not clear as to whether the above is already in place. If so, obviously my remarks in this regard are superfluous.

I strongly believe that all other applicants from the United States, regardless of their status with the ACGME or ABMS should continue to follow the current regulations in applying for a provisional license.

I did want to make two additional comments. Firstly, if there will be an increased number of American physicians entering our system, it may be an opportunity to study the question of American and Canadian equivalency in more depth.

Secondly, specifically with respect to physicians who have trained and have been practising in the United States, it would be important to educate them as to differences between how medicine is practised in Canada and the USA. I am thinking about fundamental differences between how our public versus private system works and how private insurance fits into the picture. It is crucial to understand the expectation that Family Physicians in particular are expected to be aware of and refer to social service agencies (and at times expedite such referrals) and, ofcourse, to make them aware of precisely what is available as well as the practical aspects of making referrals to varied agencies. The entire issue of medicine being practised with a mind to potential litigation is another significant difference that has actual consequences for investigations and treatment decisions. There are probably a number of other considerations in how medicine is practised and I imagine that the above would be addressed before American doctors actually practise in Canada. Accordingly, I agree that the orientation program mentioned at the end of the discussion of the first proposal is extremely important for both physicians newly practising in Canada and for their patients.

Reducing Barriers for Provisional Registration of Family Registrants:

Reducing the amount of time required during which a physician has practiced from "at least three years of practice experience in family medicine in the preceding five-year period" to "a total of at least 960 hours of direct patient clinical experience in family medicine in the preceding 36 months" is such a dramatic decrease in clinical time that it cannot help but affect competency. This would be particularly true of physicians early in their careers. Relative to our own Canadian medical school graduates, six months is one-quarter of the time that we expect they need *after they graduate from Medicine* to qualify as Family Physicians. Undoubtedly, some of the applicants will have more experience in their country of origin but as the proposed amendment is written, an applicant need only have completed whatever their version of a residency program is six months earlier and have worked for the subsequent six months. And I am assuming that they do indeed have a residency program and that the residency program is both relevant and is of even roughly equal quality to our own. It is inconceivable to me that a Canadian trained family practice resident at any stage of their residency is less qualified to practise medicine than a (for example) Nigerian physician who graduated six months earlier and has practised medicine since that time. Yet this proposal, if accepted, would allow an International Medical Graduate to practise Family Medicine (which I would argue is the most complex and difficult area of Medicine to practise) after only six months of clinical practice in their country of origin. The fact that they would "typically require a Workplace-Based Assessment" cannot even begin to compensate for the lack of clinical experience these physicians may have. While a WPBA sounds comprehensive and like a very fine teaching and assessment tool on paper, the reality of the situation with the demands of even an artificially "slowed down" family practice is not unlikely to produce a far from ideal set of circumstances for teaching and supervision.

None of what I have written thus far even takes into account language difficulties and/or difficulties with comprehension related to unfamiliar accents. I know that what I have written may be construed as politically incorrect but it in no way reflects negatively on the IMG. It is a simple fact – people from different places have different accents and sometimes they are difficult to understand. I am thinking not only of our patients but also of the internationally trained physicians. It is unimaginable to come to a country that is not only foreign geographically but also culturally strange and to be expected to function in a foreign medical system using an unfamiliar language or perhaps a familiar language but with an accent that results in patients not understanding what you are saying so you constantly have to repeat yourself, etc. etc. and all of this occurring in the context of the multitudes of major struggles that many of these physicians and their families by necessity must deal with.

So I have grave concerns that accepting this proposal carries with it a significant risk of medicine being practiced incompetently. And I believe that putting the IMGs in the unenviable position of being expected to practice at a level that some (if not many) cannot reasonably be expected to achieve is doing them a disservice as well.

"CPSM and the Manitoba Faculty believe that these changes will increase the number of individuals who meet the registration requirement and Practice Ready Assessment eligibility…." It is my understanding that the purpose of the proposed changes is to do precisely that. However, I am unclear as to why it is thought that the change would "improve the likelihood that (the IMGs) will successfully complete the requirements of provisional registration". I would have thought the requirements would be unaffected or, if anything, negatively affected by the registrants having less previous clinical experience than in the current system.

Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A” if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction:

I want to begin by clarifying one point: In the Rationale it is explained that”….use of the title is in conjunction with the Clinical Assistant title. This is to avoid confusion that they are licensed and practicing as a physician or surgeon. An example of how this will be used is “Dr. Smith (Clinical Assistant)”.

This suggests to me that written (as opposed to oral) reference is being described since one doesn’t say, ”This is Dr. Smith, Clinical Assistant.” If that is the case and the correspondence is not being sent to a patient I support this practice. The same would apply to notes that are being made about the Clinical Assistant or any other written situation.

However, if it is a spoken situation that involves a patient (as in “Hello Ms. Jones. This is my Clinical Assistant Dr. Smith.”), it is another matter. In this situation it may be both confusing and misleading for the patient. When I was in medical school working on the wards (back then it was our 4th year but we were definitely not MDs), we were not infrequently referred to as ‘Dr.’ and it is comparable to this situation because the attending would generally say something like, “This is Dr. [redacted] She’ll be working with me today” or “she’ll be asking you some questions and she and I will discuss it when she’s done” or the like. I would usually explain the situation to the patient if I were left alone to do a history or physical or draw blood etc. Most often they would express surprise or tell me that they wondered whether I was a student or a real doctor although occasionally they wouldn’t express anything verbally or nonverbally. But there were enough people who assumed that I must have a level of knowledge or competence that I did not have, to think that using the title ‘Dr.’ is ill advised in the current situation as well. Rather than “avoid(ing) confusion that they are licensed and practicing as a physician and surgeon.”, the inclusion of ‘Clinical Assistant’ serves as a mixed message. After all, if you don’t know what a Clinical Assistant is (as patients do not) how would you know if they are licensed physicians? Come to that, surgeons often have assistants who <u>are</u> licensed physicians. People could ask but are afraid of being considered rude, or feel as if they should know and do not want to look stupid, or for whatever reason do not tend to ask when there is this sort of confusion. It is likely to be less of a problem when the Clinical Assistant has graduated from a Canadian medical school or residency program because they have a recognized MD (an assumption on my part). Somehow when you are not yet licensed in a foreign country, even if you have been an MD in your country of origin it would likely feel less jarring/hurtful/insulting than if you have been an MD and have already been referred to and treated as such in Canada.

The fact that other health care professionals use the ‘Dr.’ title is an irrelevancy with respect to my concern. I cannot imagine it contributing to a patient’s confusion about what a dentist or optometrist etc. knows or does not know or what they can do or not do. The reason that is a problem in this context (apart from the patient’s uneasiness or confusion) is because it could make a patient less likely to ask the doctor a question, to give the doctor information, or in some other way to change what transpires between the patient and the physician. And that affects patient care.

Thankyou for giving me the opportunity to share my thoughts and concerns. I hope it has been helpful.

[redacted]

Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A.” if they have a medical degree from a nationally approved faculty of medicine in another jurisdiction.

Common trends identified:

Patient safety, confusion, misleading
Credentials in question
Workplace issue (dignity and respect), not title issue
No problem/neutral about the proposed amendment. Agrees with CPSM’s terms and rationale
Unclear feedback
HARD NO. Greatly opposes proposed amendment

Patient safety, confusion, misleading

I have research assistants who have spent many years in my clinic and understand gi medicine very well. But they are not doctors and the public should not feel they can rely on them to the same extent as doctors
I strongly oppose this change as it will be confusing to patients and other providers as to the qualifications of the individual involved. Patients may assume that the clinical assistant is ultimately responsible for their care and has the same qualifications as a physician. Likewise, other providers including physicians, nurses and allied health may make the same mistake. While clinical assistants make a valuable contribution to patient care, they are not physicians. Allowing them to use the title Dr will ultimately blur that line in the eyes of patients.
More importantly, it would really confuse patients. This gives the illusion that there is little difference between family MDs and clinical assistants when in reality there is a massive difference including a more arduous pathway to get into an MD program (MCAT (which has to be studied for and frequently written multiple times), MMI interview, Caspar, university grades) and then a minimum of 6 years of training with arduous call schedules etc vs a relatively superficial 2 year training program. (I teach in this program) It really would be unfair and dangerous to the public to have them think that these roles are interchangeable. The term doctor should be reserved for those who have truly earned it by completing an MD and the additional postgraduate training that is required, I respectfully plead with you to not carry this forward. It would be very harmful for our profession as a whole **Follow-up email sent:** In reading this over more carefully, I realize that I was thinking that this was for 'physician assistants' not 'clinical assistants' who have already obtained a medical degree somewhere else. I still think that it is confusing for the public to know what the qualifications are and what authority the clinical assistants really have. I believe there are processes in place for them to get licensed in Manitoba and once this occurs, then it would be reasonable to refer to them as doctors.
I strongly oppose the following:

"3. Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A.”" There are a number of reasons why Clinical Assistants should not be calling themselves doctors within our system: - Using the title "Dr." or "Doctor", regarding of putting (Clinical Assistant) in a note or document, makes them virtually indifferentiable from physicians to an average patient. Clinical Assistants, as we know, are physician-extenders. To a patient, they won't be able to understand the difference between a C.A and a Physician if the C.A is referring to themselves as doctor. For one, many physicians do not see patients seen by their physician-extenders and so any interaction that someone has with a clinical assistant referring to themselves as "Dr." or "Doctor" can be very easily misconstrued by a patient as having been an interaction with the physician they are meant to see. This has the potential to engender mistrust and confusion in patients, which hurts the profession and undermines the title of "Dr."/"Doctor". Additionally, it is a common concern from patients that they will see a physician-extender, not see the physician and then this can incite a flurry of negative emotions ranging from anger, worry, anxiety and disappointment. Having a Clinical Assistant refer to themselves as "Dr." or "Doctor", yielding confusion for patients, will stand to amplify these negative emotions in many clinical interactions. In summary, it is my understanding that as a regulated profession we must protect our patients. Adding "Dr." or "Doctor" to a Clinical Assistants title does the exact opposite as this sort of addition has great potential to create confusion and negative emotionality around interactions with Clinical Assistants. This stands to hurt the profession, undermine the title of "Dr."/"Doctor" and engender mistrust in the College and the Physicians who are overseen by the college. I strongly urge against using the title "Dr."/"Doctor" for Clinical Assistants as outlined by the opposed amendment. I would be happy to speak further with anyone if they have questions regarding the information I am sharing or are seeking further thoughts/information from my perspective
I would like to respectfully express my concern regarding the use of the title "Dr" by Clinical Assistants (CAs). In my opinion, this practice contributes to significant confusion among patients—particularly those with limited familiarity with the healthcare system. When CAs present themselves using the "Dr" title, patients may reasonably assume that they are seeing the "most responsible physician" for their care. This kind of misperception can unintentionally impact patients' understanding of their care, including who is responsible for key decisions. Clear communication about roles helps preserve trust and supports truly informed consent. Patients deserve to understand who is providing their care and what qualifications that person brings. This misperception can undermine informed consent and the trust that should exist between patients and their healthcare team. Additionally, from a practical standpoint, this ambiguity creates challenges in continuity of care. For instance, patients often present to the clinic stating they’ve previously seen "Dr. Smith," only for it to be clarified later that "Dr. Smith" was in fact a CA. This confusion makes it more difficult for front staff to track down appropriate documentation such as consultation notes, ultimately hindering patient care. I deeply value the essential contributions that CAs and PAs make to our system. However, titles matter. The distinctions exist for a reason, and clarity in these roles is essential for both patient safety and system function.

I am opposed to Clinician assistants using Dr. before their name. Recent data coming from the UK shows that patients want clarity regarding who is a physician and who is not. Allowing clinician assistants to use DR will definitely not improve clarity/transparency to patient care. Also I really believe this question should be asked to patients and not to physicians. Myself as a patient I would also like to know who is a trained physician and who is a clinical assistant. Them using DR does not let patients know the difference.
In regards to allowing Clinical assistants to use the title "Doctor": I disagree with this as well. The title "Doctor" should only refer to those who are residents or practicing attending. Adding "Doctor" to clinical assistants would only lead to confusion for the public and patients who may not be familiar with how our medical system functions.
This change will NOT improve clarity for patients or families. If a nurse also happens to have a PhD in Archeology, that nurse does not work as "Dr. Jones, RN, BN, PhD" when providing clinical care. They provide clinical service as "I. Jones - GDRN". They become "Dr. Jones" when giving a lecture on Archeology at a University.
For the third proposed amendment, however, I wish to register my strong objection to allowing physician assistants to call themselves “doctor”. I understand the rationale, but feel that it is inappropriate and very misleading to the public.
I think that allowing clinical assistants to use the title “Doctor” is inappropriate. Although they may have medical degrees from other countries, the majority of clinical assistants do not, and having them refer to themselves as doctors will contribute to patient confusion and erode the standard of education, practice and responsibility that medical doctors adhere to. The suggestion that because naturopaths and chiropractors also refer to them as doctors, it’s reasonable to allow clinical assistants to do the same doesn’t really make sense either; naturopaths and chiropractors are both professions that cause harm to patients either through their interventions (or lack thereof). I am firmly opposed to this change.
There is already much confusion from patients wondering who is providing them care. Are these people nurses (no standardized uniform) or Aides; NPs, Resident MD trainees, CAs, PAs or attending MDs? This change will add to the confusion and mistrust for competency of care.
1. Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba? While the intention to recognize the qualifications of Clinical Assistants (ClAs) is commendable, allowing them to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” does not address a regulatory barrier to independent medical practice. This change offers symbolic recognition but does not facilitate licensure or expand the scope of practice for ClAs in Manitoba. **2. Do these changes negatively impact patient safety?** Yes, the proposed amendment could negatively impact patient safety by causing confusion. In clinical settings, the title “Doctor” is commonly associated with individuals licensed to practice medicine independently. Even when paired with “Clinical Assistant,” the use of “Dr.” may lead patients to mistakenly believe they are under the care of a fully licensed physician, potentially affecting informed consent and trust.

3. Are the current regulatory requirements appropriate?
Yes, the current regulations appropriately restrict the use of the title “Doctor” to those who are licensed to practice medicine independently in Manitoba. This ensures clarity for patients and maintains the integrity of professional titles within the healthcare system.
Additional Comments:
While recognizing the international qualifications of ClAs is important, it is crucial to maintain clear distinctions in professional titles to prevent public misunderstanding. Alternative methods of acknowledging their credentials, such as detailed introductions or informational materials, could be considered without altering title usage.

I do not think this is a good idea. Although it is true that other types of professionals use "Doctor" these are all within non-medical environments that clearly delineate that professional as being a "different sort of doctor". Although the guideline here would require that clinical assistants introduce themselves as Dr.XX Clinical Assistant, I am skeptical that this would be routinely done, and I think that this will create more confusion in spaces where there are already frequent role confusion for patients. If a clinical assistant sees a patient on the ward and introduces themselves as "Doctor" I believe this will introduce more role confusion, patients understand what a doctor is but may have uncertainty what the additional designation of clinical assistant means.

I agree to items 1 and 1 but not on item 3. My rational is that calling CA doctors will definitely lead to confusion among the public about MD and CA specially that both could be practicing in the same facility. Optometrists, dentists, chiropractors, and naturopaths all have different parhways the medicine and they are well recognized by public as different professions than MD.

As for titles, I think clinical assistants should not be using the title doctor as it can lead to confusion as to who is responsible for patient care. While I do recognize the training that many of the clinical assistants have their is also many backgrounds within that professions ranging from RT, RN, PA and MD. the position of clinical assistants is important and they should be respected as such however I feel that unless they are in the role of a practicing physician they should not use that title.

Absolutely not. There are too many "professionals" calling themselves Doctor with questionable backgrounds (naturopaths, anti-vaccine chiropractors) and adding to the mix a "doctor not doctor" will merely confuse the issue. Patients already do not understand the role of a PA or Cl A and adding a title of doctor to the Cl A is a terrible idea. We know which title will be held in patients' minds with any introduction.

Many foreign professionals with PhDs could be called Doctor even if not recognized here in Manitoba, and while that situation is difficult for them, their current profession is what is understood in current context, not what non-recognized credentials they achieved elsewhere.

The argument that the title could be used while in residency is spurious, as these individuals are no longer in residency. They have transitioned to another profession.

I think patients will be confused and I cannot think of how to easily remedy this. Do we really want the professional having to explain they have a medical degree from another jurisdiction that allows them to call themselves a doctor but that their scope of practice is different than the other person on the unit who also identifies as a doctor? Sounds terrible. You compare this to the dentist and chiropractor who use the term doctor. I think it is common knowledge that when seeking dental or skeletal pain care from a dentist or chiropractor, the scope is limited to this

system. Same goes for the vet or psychologist who uses the title Dr with qualification. Perhaps you plan on a new and ongoing public education campaign to introduce people to this new rubric.
I understand the rationale; my only concern is that patients already struggle to distinguish/recognize the CI.A. role is not that of a physician. If the CI.A. is to use the title of Doctor, then surely the CPSM should just offer them a limited licence / restricted licences pathway, until they meet requirements of the practice ready process for full licence. *As such I do not support the proposed change*.
I have read the proposed changes for allowing clinical assistants to use the "Dr" designation. At present I do not think the general patient population even knows what a clinical assistant does and then to add the title would cause further confusion about provider roles.
Questions to consider: *Do the amendments remove unnecessary impediments for qualified individuals applying to practice medicine in Manitoba?* *Do these changes negatively impact patient safety?* *Or are the current regulatory requirements appropriate?* I do not see any impact, either positive or negative, on the recruitment or ability to practice for clinical assistants in the province. I would be concerned with regards to a potential impact on patient safety, and the added confusion of yet another group of individuals referred to as doctor. If anything, patient safety and clarity could be better served with the reduction, not the increase, in individuals able to identify themselves as doctor. When working in the capacity as a clinical assistant, that individual does not require the title of doctor and is not working in the capacity of a medical doctor but under the supervision of one. This is not to say that their medical degree is not valid or is irrelevant, however in that particular capacity, the title of Dr. would be potentially misleading and confusing for patients and other healthcare staff. In this case the current regulatory requirements seem to be appropriate.
I think it is misleading to patients who already don't understand the differences between chiropractors, physicians and someone with a PhD.
It makes no sense why the CPSM is engaging in this activity. Frankly, adding another health care associate to refer to themselves a "Dr." will lead to further confusion among patients, as opposed to "avoid confusion" as per the change. Of the other health care professions who use the title of "Dr." in MB, very rarely do they identify their profession. Just look ash their advertisements or online web sites. They do not include the post-fix designation. I've spoken to many colleagues in regards to this proposal. We all are in agreement that this is not a beneficial proposal and should be pursued further.
While I appreciate and value the contributions of Clinical Assistants (CAs), I have reservations about permitting the use of the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A." The public often associates the title "Dr." with licensed physicians, and may not fully grasp the significance of accompanying designations. This could create confusion about the scope and authority of Clinical Assistants. I have personally experienced situations where patients question my credentials or authority based on preconceived notions of what a physician "should" look like. Introducing another

provider category with the title "Dr." may further complicate public understanding, potentially exacerbating these issues and requiring additional efforts to educate the public on provider roles.
While I appreciate the motivation behind the proposed change, I am concerned about the interpretation of such care by a patient. The role of clinical assistant is not identical with the role of independent physician (which general public typically associates with the label of "doctor"). I am concerned about the message given to the patient that their care is being provided by a physician. I have similar concerns about the physician in the clinical assistant role expanding the boundaries of their role. I am also curious about the choice of the label "doctor". I don't consider it a title in the sense of a credential. I would find it much more appropriate if the clinical assistant used their degree (MD or equivalent) beyond their name (as an educational credential). Choosing a much less formal and much less descriptive label "doctor" is concerning for me for reasons described above. I believe that the public's interpretation of the label "doctor" is equivalent with the physician role which is not equivalent to that of clinical assistant. See my signature at the end of this email that illustrates my credentials, my position and omits the generic title of doctor which I use in my role as clinician/physician when treating patients. In summary, I oppose the proposed change for reasons described above.
While I fully support the use of a persons credentials because of the work and time that is required to achieve such milestones, I fear it will cause confusion for the patients that we care for, especially the elderly and for those who's first language is not English.
I have also heard from some of my counterparts that the use of Associate Physician title is causing confusion for patients seeking health care due to the use of Physician Associate for the title of PA in Europe and which is being looked at as a change to the title in the United States.
While I acknowledge that there are other jurisdictions and other health care professions using this title, most Physicians disagree with the widespread use of this title amongst non Physicians, and the escalating 'scope creep' of both this title, and health professions who are 'practicing medicine' both without actual training in medicine and without being held to the standards of medicine. More importantly, it leads to confusion for patients as the general public thinks of Doctor synonymous with Physician - specifically in the medical setting that Clinical Assistants will be working in – alongside Physician counterparts – this gives high potential for confusion for the public regarding who is the actual Doctor/Physician.
The title doctor should be reserved by licensed and practicing physicians in MB. Adding Dr. For the Cl.A may become very confusing for the patients and pharmacists. I don't think patients will appreciate this change.
1. It is harmful to the public to call Clinical assistants a Doctor (regardless of whether the term "Clinical Assistant" or another term is attached) because it obscures for the public the difference between types of health practitioners, and part of our mission is to make the health system easier to understand…. more accessible in understanding and therefore promote clarity in interpretation and use. The onus is not on the people we serve to try to parse wording. The term "Clinical Assistant" is clear enough. The public should not be put in the position of making errors in their understanding of who in their care giving team has gone through the rigorous Canadian process of being granted the designation of "Doctor".

It is totally inappropriate change regulations such that Clinical assistants may be called “Doctor” (attached to other parts of their designation).
I strongly support CAs and the importance of their role in health care setting. I don’t support CAs using Doctor before their name. As a colleague I would be fine with CAs using Doctor designation, but thinking from the public’s perspective I would urge caution. I feel many in the public would feel deceived. There is a high level of distrust, higher than I’ve seen in my career. I’ve been asked if I’m an actual doctor and had to defend myself. If a person is cared for by a CA, they should know they don’t have an MD in Canada. Identifying someone as Doctor would lead someone to think they have these credentials in Canada. If someone sees a dentist or optometrist, they aren’t expected services a physician can give, so there would not be the same confusion. If someone has a poor outcome, and learns they were cared for by a CA with a designation Doctor but without passing evaluations to ensure the skillset, they would have a legitimate complaint saying they didn’t know the level of training from their caregiver. I work with CAs and have many who have incredible skill sets, but occasionally some who really should not have Doctor as their title, and this could do harm. It raises the question what does Doctor even mean? Certainly you need to do public education if you pursue this course.
I have concerns about the above amendment. While in writing this may be clear but introducing oneself to a patient as doctor may create patient confusion about their qualification is they are practicing in the capacity of a clinical assistant.
Clinical Assistant or associate or any Allied professional must not use the title Dr. as this can produce negative consequences with regards to patient safety and might increase complains too because of the unclarity of who the patient had consultation with. The title Dr. should not be mixed with any other allies.
Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A. It could make lots of confusion and misunderstanding for patients as patients mainly couldn’t differentiate the difference of a CA and MDs and it could potentially increase the rate of college complaints. At the end of the day, a CA should practice under supervision of a MD, so changing a title not only make any considerable difference, but also could cause unnecessary problems for MDs.
Neither residents nor PA’s or NP’s generally make use honorific titles in their medical documentation or communications in Manitoba. To my knowledge and experience, CAs act on the same ‘level’ ie under direction/supervision of attending physicians who are titled “Dr”. In my experience in navigating the hospital system the Dr. title is very helpful in identifying the Most Responsible Physician/Consultant when filing through large charts or EMR records. I would suggest a CA remain under the current nomenclature, just as a PA would sign “name, PA” or “name, MPAS” or a nurse with NP, or resident with PGY4/Resident. I see no workplace efficiency improvements with the title change and am concerned that a novice “CA” documentation may be confused with attending level charting/directives and delay urgent identification of key decision makers in patient care.

disagree. It is misleading to use the title doctor if not credentialed as such in the jurisdiction in which they are providing care
In acknowledging that other professionals use the title, including dentistry etc, I would also like to point out that those professionals are medico-legally responsible to those patients. The position of CA is unique in that the supervising physician is responsible. I feel that only those ultimately responsible for the end outcome of patient care should be allowed to use the title, as this confuses patients along with the placement of responsibility that should be respected. Therefore, I disagree with this proposal despite the uptake in other provinces.
I oppose the proposal to allow CAs to refer to themselves as doctor. I believe that this will confuse patients with regards to the role of the CA, and will undermine trust in the system if they find their care inadequate.
For the Clinical Assistant - the complicating factor is knowing who the physician of record is. It is already somewhat difficult to determine if I am speaking with a physician or clinical assistant as this affects who I establish communication with and also for billing purposes. A form such as Dr. J Smith (CA for Dr. D. Jones), will address this concern.
I am not in support of Clinical Assistants allowance of the term Doctor. Many clinics are already using a Physician extender and the confusion amongst patients is profound. They believe they've seen the supervising Physician but in reality they have seen a CA calling themselves the Doctor. We are watering down the respect of the medical profession by allowing these small differences to creep in.
In relation to proposal 6(9), I disagree with the consideration that Clinical Assistants be able to also include "Dr." or "MD" in their names. Cl As and PAs are often clustered together as mid-level providers and are distinct entities from physicians. Being relatively new to the Canadian health team market, the public is still acclimating to the existence of PAs and CAs. There is still a lot of confusion around how to conceptualize where these roles fit within people's constructs of health teams. Adding in nomenclature that positions CAs as a variant of MDs, would further complicate this, leading to muddying of all CAs, PAs in the eyes of the public. If we are trying to establish these career trajectories as independent professions, there needs to be clear separation of mid-levels from full phyisicians. Once the CA completes their pathways, MLP-IMG programs, etc, then it would be completely appropriate. But before that, not all CAs have their MD, and I don't see any gains beyond acknowledgment of past (though potentially not parity to Canadian standards) educational achievements but if they're not practicing at that level, they should not be mis-representing themselves as "dr" when introducing themselves, nor signing off on things that a CA does not have privileges to do, and it could lead to a pile of complaints, safety breeches and role creep. I was formerly an ICP paramedic, but rescinded that title when I completed my PA training. This would be like me signing off on patient transfer records as an EMT, because I formerly held this title, accredited by an institution, but don't practice at that level anymore. It would be inappropriate.
I recently sent an email with my concerns about CAs being able to use the title "Dr." My main concern is that patients will be confused as to who is the most responsible "Dr."on the team caring for them. I would like to add that despite the fact that other professions such as dentists and chiropractors and naturopaths (ugh...still not quite sure about that one, but maybe I need to educate myself more about that healing profession) use the title "Dr.", I believe that their patients understand

that they are a Doctor of dentistry or chiropractic, belonging to a Canadian professional college that registers them and holds them accountable for the all of the decisions they make, as the head of the team they work with. ie: they are understood by their patients to be a certified, registered and fully independent and accountable HCP, meaning the buck stops with them and the patient can rely upon the "Dr. "title to promise them that.
As a physician who works with learners, PAs, and CAs, I have seen the confusion and even fear that misunderstandings about who the most responsible "Dr" is can cause. Despite the PAs and CAs being excellent, completely reliable and responsible HCPs that I fully trust and rely on, patients have ended up feeling mislead or even betrayed by the "Dr" title. (Not that the "Dr" title is routinely used for PAs or CAs where I work, but my particular patient population frequently does not understand the nuances of a non-Canadian-licensed MD, and despite our best efforts to explain, inevitably a patient will refer to a PA as a "doctor" and other patients will then think that PA/CA is a "Dr" as they understand myself to be. Now that we have had PAs/CAs for years, the community is beginning to understand what a PA/CA is, but there has been a lot of confusion along the way, especially with the rotating nature of our medical/PA/CA team here in the north).
My patient population is a vulnerable one, and I suspect that a more socially-advantaged and higher-educated population might appreciate the nuances about a "doctor" with certification from another country/jurisdiction, not yet Canadian-licensed. I have seen it many times where the title "Dr" for a non-Canadian-system licensed MD has led to confusion and erosion of trust, as I mentioned above.
I believe we need to protect the title "Dr" when it comes to Canadian-licensed physicians as the nuances can be confusing and even harmful to certain patients if they believe their PA/CA is the Canadian-licensed, most responsible "Dr" they expect them to be, but are not technically licensed as the patient expected; ie: "stamped" with the legal, Canadian-licensed and authorized "seal of approval".
This is subtle, I know, and likely only applies to the more vulnerable patient populations like the ones I work with, but this makes it even more important to ensure this particular patient population is not inadvertently mislead about who they think are their "Dr"s, as trust is so fragile at the best of times, and these vulnerable populations tend to be over-represented in acute care settings like ERs and Urgent Cares where there is no time to explain the subtleties. Confusion in these settings is dangerous as there is no time to deal with these subtleties due to the nature of the care environment, and patients' misunderstandings or feelings of betrayal can lead to more distrust in the long run, leading to more health problems and care burden in future, like the proverbial snowball.

I am not in favor of this amendment. I provide this feedback in the context of having directly supervised several Cl.A.'s with medical degrees from other countries, as well as having supervised PhD graduates who are also eligible to use the title "Dr." My reasons for not supporting this are as follows:

1. Cl.A.s are not working in the capacity of a physician, and therefore should not use the title "Dr." in that work – regardless of their previous training. If they were working as a physician, they can call themselves "Dr." If they are working as a clinical assistant, they should refer to themselves as "Clinical Assistant"
2. When a Cl.A. uses the title "Dr.", it is misleading to patients and staff. We tried this with one Cl.A. who was under my supervision and working on our clinical team. It led to confusion with patients and other members of the multidisciplinary team, in terms of role

clarity and treatment expectations. Especially with patients and families, transparency and accuracy are of utmost importance.

3. An analogous situation would be a medical student who has already completed a PhD prior to medical school. This student would not introduce themselves to patients as "Dr." while on clinical rotations in clerkship. Regardless of previous training or degree accomplishments, a provider uses the title that fits with their current role in that setting.
4. Unless we have rigorous evidence that supports that Cl.A.s using the title Dr. improves recruitment and retention of internationally trained physicians in the MB healthcare system (compared to not doing so, or compared to other jurisdictions) – we should not make that claim.

As a Clinical Assistant, I often found it difficult to explain to my patient why I am not a resident doctor and not a Physician Assistant. Many of them become embarrassed that they allowed themselves to be seen by me in the first instance. The conversation usually end up as I am a foreign trained physician but not licensed to practiced independently. The word Clinical Assistant could be misleading and sometimes people with little command of English may not even understand until you say 'I am assisting Dr A or B' and you can now be accused of impersonation due to the language barrier. If C As are allowed to use the word Associate Physician it will be easier for them to perform their duties.

I feel like allowing CA's to use the title Dr or doctor would add to an already existing confusion in the medical field. My patients already (and myself often included) are confused about the roles of PAs vs CAs vs NPs. Patients often think they saw a doctor when they actually saw the PA in the ER. I feel like if staff are equally confused, it may lead to patient safety issues. I also don't really understand from the description who would actually fit into this category.

I believe the third proposed change could result in additional confusion around the use of the title "Dr." and the lay public may not fully understand the nuance of use of a conjunction.

Credentials in question

I am very much against PA or CA using title of doctor. If they have a masters they are not doctors by any standards. If they were doctors in another country they have to have the certification that says they are capable of being doctors in Canada.

There is a big distinction between MDs (Doctors) (who spend many more years of intense training) and clinical assistants. Currently patients associate the term Dr with that degree of training and expertise. To provide that designation to clinical assistants would be demeaning for all true MDs. I think this would be degrading for our profession. The image of physicians has eroded over time and this would enhance this erosion.

NO, I do not agree with putting the hard earned title of a doctor in canada to anyone who is nit fully licences to work as a physician in Canada...
We spent years and years to earn this title and giving it away that easy to any non Canadian licences physician meeting the Canadian standard is disheartening.

In addition, the training of many clinical assistants is very different from our Canadian medical training and some do not have adequate training to practice as "doctors", hence the use of this title should be restricted to those who are residents or attending physicians.

In the realm of clinical service provision, and in all scenarios where a provider is interacting with consumers of the health system on an individual level, the titles "Dr." and "Doctor" should be reserved for graduates of medical schools who are licensed in Canada as PHYSICIANS.
Anything else is confusing.

The fact is that if someone does not meet Canadian and provincial requirements to be a practicing physician, they are simply not a doctor and self-labelling as such will lead patients to believe that they are being cared for by someone who has met the appropriate qualifications. This goes against our mandate to be honest and forthcoming with our patients, always. The fact that naturopaths and chiropractors can do this now is not a valid argument; I suspect if you asked most physicians if that is appropriate they would tell you that it is not, and it does harm to patients by increasing the legitimacy of individuals marketing what are at best placebo treatments and which are at worst harmful interventions. Thank you for giving us the opportunity to give feedback. I hope it is taken seriously and that withdrawal of the third proposal is considered.
Having ANYONE using "Dr." or "doctor" who is not a full MD independently able to practice with a Medical University Degree is an outrage to those of us who do hold this level of certification and expertise. It is no easy task to earn an attending physician designate that comes with substantial lifestyle and monetary sacrifice. Further, the MD is an earned degree- how dare this organization allow someone who does not possess this degree use its social title.
3. Absolutely and unequivocally no. Full stop, never acceptable. If the clinical assistants (as mentioned, are physicians from countries whose training is not equivalent to Canadian) want to be designated as doctors in Canada, they must complete a Canadian residency. As with issue #2, it is profoundly unfair to patients to produce this facade that they are being seen by "doctors" who have no authority to be so. There is no such thing as a "Doctor of clinical assisting". The fact that this is even being brought up is ridiculous to be honest. Clinical assistants are clinical assistants.
1. In your rationale you state that these individuals have medical degrees and were able to use the title doctor during their training in other jurisdictions. Although this is an accurate statement it is not rationale. I would assume that these folks were afforded this privilege on the assumption of successful completion of the training program to practise in their local jurisdiction. However, for a variety of reasons this assumption was not fulfilled. I can understand that this is disappointing to the individual. The solution is not a title change rather more opportunities for foreign graduates or those with incomplete qualification to access medical training and practice as physicians in Canada. This is the problem. Title changes are meaningless. These individuals need opportunities to increase their scope of practice and economic reward. **2.** These professionals have completed a masters that qualifies them to be physician assistants/clinical associates. Differentiating them from other clinical assistants, who also hold advanced education, is in my mind an ill conceived idea. Either all get the title upgrade or none.
I am not in favour or support of the third amendment: **Allowing Clinical Assistants to use the title "Dr." or "Doctor" in conjunction with "Clinical Assistant" or "Cl.A."**

Clinical Assistants, as a role, does not have the same responsibility (clinically and legally) as a licensed physician within Canada. Regardless of their clinical background internationally, acting as a physician is not in their lane or roles. Additionally, we deal with an incredibly disadvantaged, vulnerable and low literacy public demographics in Manitoba. If we are serving our patient well, we should not be endorsing in blurring the lines and misrepresenting their care. Medicine is already considered a black box. A lot of our patients do not get the proper care in regards to education related to their diagnosis, management or address of their concerns. This amendment lacks consideration of the patient perspective or the impact of this proposed communication and the dangers it poses to our patient population. The title of "doctor" is of incredible responsibility and one of extensive work and consistent commitment to obtain. I do not support this amendment. While I cannot vote against its use in other health care professional roles, I am asked to discuss its use here. Additionally, a clinical assistant is an extension of a physician. A CA role is not independent but instead are an extension of the most responsible and accountable. We must be mindful of the negative implications of the language we choose to use.
2. Clinical Assistants are not practicing medicine in Canada, any more than nurses or other health workers are. They are practicing health care. **3.** Clinical Assistants may have graduated from nationally approved medical programs in other countries, but we have no way to know whether they meet the standard of a person who is called a Doctor in Canada. We are talking about a person who is not licensed to practice as a doctor in Canada, that is clear. But we are also talking about a person for whom we have no proof that they have the knowledge and skills at the level of a graduate of a Canadian medical school.
I do not agree with Clinical assistants being able to use the term Doctor or Dr. in Canada if they do not have a Canadian Medical degree or equivalent. The term Doctor is a privilege and is earned and what is required to use that term is dependent on what any given jurisdiction decides is required to be an MD. There is enough confusion about the term amongst lay people and this only adds to that confusion as well as cheapening the value of the title here in Canada.
This title is granted in lieu of several years of Medical degree and should not represent anyone who is not formerly trained or did the full education. If for instance a clinical assistant has completed medicine degree in other jurisdiction they should be allowed to use the title once achieved full licence in Canada. This restriction will allow them to work towards gaining full licence. The thing which should be considered is that if clinical assistant has a medical degree and proof of practice in their hometown they should be allowed hands on practical assistance under supervision of clinician to speed up their license. Also the number of training years should be reduced on discretion of the clinician/physician they are working under(practice ready assessment).
To refer to yourself with the title doctor (medicine), you should have passed Canadian boards to do so
My other concern is not with the changes, but how we assess international medical degrees: "(i) a medical degree granted from a nationally approved faculty of medicine" My understanding is that this is derived from the world directory of medical schools. I'm not sure what accreditation processes this organization uses, but in my experience working with foreign trained physicians there is enormous variability in knowledge and competence. I do not believe that every medical school that is in the directory can be considered equivalent to a Canadian M.D. For example, Afghanistan is listed as having 41 faculties of medicine. This is a country that has been at war for decades, has excluded women from education, has a similar

population as Canada, but somehow has double the number of medical schools as Canada. I find it difficult to believe that the Alberoni University Faculty of Medicine near the small city of Golbahar, Afghanistan, with a 70 bed teaching hospital is equivalent to McMaster or UBC.
Clinical assistants have not gone through the same training as Canadian grads, and it is my experience working alongside them that their knowledge base, ability to develop a differential and create a safe management plan - are frequently lacking. I have not yet worked with a CA that has not required significant guidance and oversight from a medical doctor while practicing. Their use of Dr will mislead the public into believing their skillset is as honed as Canadian Doctors, which is simply not true.
Questions rationale on enhancing dignity and respect
International medical graduates who are working in NON-PHYSICIAN roles should not be introducing themselves as "Doctor". If they feel that this restriction is limiting their dignity, they could request to have their degree credentials listed on a Hospital or Clinic ID badge (John Smith, Clinical Assistant, MBCHB / MBBS / MD / PhD / etc). The decision to list these details could be up to the hospitals.
I have no feedback for 1 or 2, but do **NOT** believe the use of the title “Dr” or “Doctor” is appropriate for clinical assistants. The title of “doctor” is not a criteria for designating merit or how good someone is at what they do. By the rationale provided below, all medical professionals (OT, PT, nurses, etc.) should be able to use the title “doctor” such that we honour the “professionals’ credentials through appropriate dignity and respect”.
The rationale being to enhance "appropriate respect" is a workplace issue, not a title issue, and strong-arming the public or coworkers into deference due to an inappropriate title is ridiculous.
The rationale states that this would foster a more respectful environment. I work with these health professionals and teach in their program. I was not aware that they are not afforded respect and dignity. If indeed this is lacking, oh boy, we need a different approach to improve the work culture. The title change risks backfiring and being seen as disingenuous by all.
I disagree with the proposal and I don’t see the logic in the rationale put forth . Is it being suggested that a PA would gain more respect when using the title of Doctor. Yes, they probably would because it is a prefix that is not easily earned by a physician. It seems to undermines the effort that goes into medical training when the title can be casually bestowed on other medical professionals.
Supportive/neutral about the proposed amendment. Agrees with CPSM’s terms and rationale
I support this amendment. Allowing Clinical Assistants with medical degrees to use “Dr.” in combination with their title (e.g., Dr. Smith, Clinical Assistant) offers deserved recognition while still maintaining transparency with patients and colleagues. In conclusion, these amendments represent a positive step toward a more inclusive and practical regulatory framework. I encourage CPSM to consider adjustments that reflect the realities and timelines that many internationally trained physicians face after arriving in Canada.
It seems unfair not to allow someone to use the title Dr. if they actually have an MD or equivalent from a legitimate training program somewhere. The risk is the potential for the public to be

misinformed as to whom they are seeing. If we were to allow this, then there would be have to be significant protections against that. **1.** It would have to be strictly enforced that they only be able to use Dr. in conjunction with "clinical assistant" and never on its own in any medical context **2.** We would need some process/criteria to determine whether their degree is in fact equivalent to an MD. **3.** Assuming such a verification is in place, a clear and transparent way of informing the individual of the result of that verification, and recording in their registration somehow whether are or are not allowed to use Dr.
I agree to add title doctors to physicians' associates as this will encourage more candidates to enrol in this program.
I fully support allowing us to use the title "Dr." along with our role for example, "Dr. [Last Name] (Clinical Assistant)." Many have medical degrees and have worked as physicians in other countries. Being able to use the title "Dr." would be a sign of respect for education and experience. It's something earned, and it's already allowed in other provinces like Alberta, Saskatchewan, and BC. Using "Dr." together with "Clinical Assistant" makes things clear for patients and doesn't create confusion about our role. It's a fair way to recognize our contribution to the healthcare system.
CA's, yes if they have been certified as physicians in their original countries of training, I see no objection to have them continue carrying that title while working as clinical assistant here in Manitoba.
I am very supportive of the third suggested amendment. I work with a competent Canadian physician, and I believe he deserves to be referred to as Dr., even if it is used in conjunction with CA.
I am fine with the proposal about clinical assistants too, as long as they keep the clinical assistant on their name tags. That said, I do not work with any clinical assistants, so I really don't have a right to speak to this.
I would be delighted to see this change. In Neonatology we have two CAs and to be honest they are both among our top performers. I have always found it distressing that they are unable to refer to themselves as doctors and specifically introduce themselves as such when they are so talented. With the way our CAs function and knowing their background would allow them to be physicians in their home country I think it is a small but important gesture to let them know we value them.
With regards to the change and allowing C.As to call themselves doctor, as long as it is clear that they are C.As and still working in a supported environment I'm not too concerned. By the wording it would only apply to those with an MD degree from elsewhere.
I am writing in support of the proposal to allow Clinical Assistants (Cl.A) to use the title "Dr." or "Doctor," provided they hold a recognized doctoral-level qualification. The use of the title "Dr." is an acknowledgment of academic and professional achievement, and many Clinical Assistants possess degrees such as MBBS, MD or equivalent. The ability to use a title values their expertise and contributions to healthcare in Canada.

As long as the title is used alongside the full professional designation e.g., “Dr. Smith (Clinical Assistant.) there is minimal risk of public confusion. It promotes transparency and respect for academic accomplishment. This enhances patient trust and interdisciplinary collaboration. Moreover, many healthcare systems around the world already recognize and support the use of “Dr.” by non-physician doctorate holders, provided appropriate context is maintained. Aligning with this standard reflects a progressive and inclusive approach. I fully support this proposal and believe it upholds both professional integrity and respect for individual qualifications.
Allowing Clinical Assistants to use the title “Dr.” or “Doctor” in conjunction with “Clinical Assistant” or “Cl.A.” Yes, this is a win win situation that improves the care and also trust between patients and health care providers.
Anyone who has successfully completed medical school has the right to use the title "Dr." but if they are working in capacity as a clinical assistant, this needs to be added in verbal and written communications.
I am very glad that a Dr. Can be added to our title. I also hope that we can be entitled to work as an associated physician if we hold an LMCC or a Canadian specialty license, which is similar to the policy from other provincial colleges such as CPSBC.
I agree with using title of Dr for Clinical Assistant who are medical graduates outside Canada. On the other hand, in some other province they are addressed as associate physicians which we may be able to expand for this too.
This email confirms my agreement regarding the appropriate use of professional titles for Clinical Assistants within the jurisdiction. Clinical Assistants who have obtained a medical degree from a nationally recognized institution outside of our jurisdiction are permitted to use the title "Dr." or "Doctor." However, to ensure clarity and proper recognition of their specific role, this title must always be followed by the designation "Clinical Assistant" or the abbreviation "Cl.A." This practice will facilitate clear communication and ensure appropriate recognition of their qualifications and current responsibilities.
I'm supportive of all 3 changes one comment re using Dr for CAs……while I have no problem with this change, it is potentially confusing (to the public for sure and possibly to people in the system)
In regards to calling a clinical assistant Dr., I have no problem with that as long as well don't confuse them with their MD that they are seeing.
With respect to Clinical Assistants using the title “Dr.”, I think it should be restricted to those IMG’s who are registered and are participating in the MLPIMG Program. For those internationally trained physicians who are not seeking licensure, they should continue to use the title CA (Clinical Assistant) alone.
Unclear feedback
Why did i go to school for 12 years to become an MD FRCP ??? Not sure what is wrong with their title of physician assistants?

It dose raise another questions for me as well:
Does this also mean that a Physician Assistant that receives a Doctorate degree in public heath can use the prefix and introduce themselves as Dr. Joe Smith, Physician Assistant? (I have personal knowledge of 2 PAs that have completed Doctorate degrees, one of which works in Manitoba)
With the Cl.As that work in Manitoba that have not completed a doctorate degree, will patients be confused by the difference in qualifications or the care they will receive?
Will the Cl.A have to explain to the patient that he/she is not licensed to practice as an MD in Canada which may have the patient loose confidence in the care that the Cl.A is able to provide?

HARD NO. Greatly opposes proposed amendment

I strongly object to mid levels using the term doctor. They do not need it to protect their dignity, they already have plenty. They do not need it to get respect from their colleagues. Doctor is a title with certain connotations to the community at large. And it is a title that is given to people who have done specific training.

The fact that this is even being debated makes me question whether the College is putting the needs of actual physicians at the forefront.

I would like to know what the actual motive for this is.
The government is already trying to supplant trained MDs with mid levels and this kind of action creates a false sense of equivalence that is dishonest and deleterious to the medical profession.
Reconsider, please

The College is constantly spouting the need for standardized quality care, yet it is considering diluting the title that comes with the designation, the responsibility and the workload of “Dr.” None of these groups are required to be on call, or find a suitable replacement during holidays or sick time. Most of them do not work holidays or weekends, or nightshifts. These groups do not carry anywhere near the level of moral responsibility for pt care, that are imposed on attending physicians. They do not carry anywhere near the legal responsibility that is demanded of attending physicians. They are not mandated to serve on committees, provide teaching to medical students or residents, make court appearances for medical cases, act as mentors for foreign grads, sit on grievance committees, sit on hospital boards or provide any administrative duties. They are not responsible for private medical information and its security. Further, they cannot prescribe full complement of medications.

Multiple levels of pseudo-providers using this designate will only create more confusion amongst the population with no appreciable benefit. It seems like the College is trying to purposely deceive the public with this type of branding. There is no possible way that these people will be introduced and known as “Dr X, clinical assistant.” It is too onerous. You wouldn’t call a Navigator for Air Canada “Captain, first operational nav,” or a police cadet “Sergeant, junior officer cadet.” These titles are simply erroneous and wrong.
Titles are earned honours bestowed by Academic Institutions. They are not to be handed out by a professional regulatory body when the mood strikes.
I reject this proposal in the most vehement of terms. I find it wholly disrespectful and denigrating to all of us who have worked (and continue to work) so hard to achieve this designate and level of expertise.

I accept all of the proposed amendments except allowing clinical assistants to use the title doctor. Each time another profession elevates themselves by referring to themselves with a term that is used to also refer to physicians or taking over some of our easiest tasks then they are elevated above the status that they have earned by education, work ethic and accomplishments. At the same time, physicians are diminished.
Ultimately the groups (in this case physicians and clinical assistants) will collectively be viewed by all as the average of the two groups. This is already happening as chiropractors are referred to as doctors, as are naturopaths. Physiotherapy clinics are advertising as "sports medicine." Nurse practitioners are grouped with physicians as practitioners. Pharmacists can now advertise for patients to come in for an assessment.

What are the harms of what I have described above? Well, I have a patient who's practitioner has them stand on a pad while they hold a vial of liquid in each hand. Their "Practitioner" judges their condition based on the color change of the fluids and sells them a treatment for their imbalances. Pharmacists refill medications without assessing medical history, review of systems, renal function, electrolytes etc. They treat lower abdominal pain without a urine culture. Many of family doctor's easiest tasks have been given to nurse practitioners and pharmacists increasing the work load, complexity and burnout of physicians. At the same time the stature of physicians is diminished because so many practitioners are now thought to be on par with physicians. I won't bore you with the details as to why (let me know if you'd like to have that discussion) but this is leading to physician shortages and burnout.
We appear to have learned nothing from the exodus of physicians in the 1990's. We learned nothing from the burnout and suicide rates in medicine.

Here is the key point - these changes degrading the perception of physicians ultimately impacts patient care. Why would any graduate do family medicine as a residency when the ITDI nurses in my clinic earn the same as me but they have a pension, sick days, holidays and benefits?

If you feel strongly that this strategy is useful then do it across the board and remove the "Specialty" designation and treat all physicians with the same dignity. The breath of the family physician's knowledge and experience is equal to the depth and training of the specialist at 5 years post graduation. I understand this change won't happen but think about why it won't. The reasons are very similar to what I have raised above.

Consider also why we need clinical assistants and nurse practitioners. In large part it is contributed to by a lack of interest in the degraded profession of family medicine where physios, family medicine chiropractors, nurse practitioners, clinical assistants, nurse "specialists", naturopaths etc are all be elevated to the level of the family physician, which is at it's lowest point of public perception ever. That has harmed patient care.

To represent a clinical assistant as a doctor is a misrepresentation. It smells of a lie pushed by positions and designed to placate the anxious public who cannot get a family doctor because the system is falling apart due to adequate care and respect.

I do not want government and government power bodies blurring the difference between my practitioners. I believe clinical assistants deserve the respect of clinical assistants. If clinical assistants are not respected - why aren't they? Use education to let the public know how

knowledgeable the clinical assistant is. The fact that you want to hide who they really are is a concern. Thank you for the opportunity to vent. I think burnout contributes to my crankiness. I have a strong appreciation for CPSM and their crucial work. I respectfully disagree on this issue.
Strongly Disagree. We are a self-regulating profession. To call ourselves Doctor means we have taken an oath to hold ourselves to a higher standard. We trust the college to maintain this high level of competence, and that includes the current credentialing processes. There is already an established pathway for Clinical Assistants to follow if they wish to obtain full credentials in MB and subsequently be addressed as Dr. Simply expanding the title of Dr to Clinical Assistants would negate the current processes in place and actually undermines the efforts of those Clinical Assistants who have appropriately proceeded through the system to show their competency and meet the standards that have been set. It is understood a Dr is an expert in their field, but the examples given of other health care professionals who also use Dr are not actually applicable here. The title is highly dependent on context of use. If you make an appointment to see the chiropractor, when they introduce themselves as Dr you know they are the ones responsible for your chiropractic treatment. Similarly at the dentist's office there may be many people involved, hygienists cleaning for example, but when you meet the Dr it is understood they hold the authority to make the final treatment decisions for your teeth at that visit. So, when patients come into any medical setting (clinic or hospital) as soon as the title Dr is used it is assumed that that person holds the full medicolegal responsibility for their care. Our patients will not understand the implication of the qualifier, and using the title Dr in this setting is ultimately misleading. Why does the college want to expand this title? The title Dr imparts full medicolegal responsibility and authority and is much more than simply a term of respect. In the email the college states that this title expansion is to recognize these professionals with dignity and respect, which is an issue that should be independent of title. All members of the health care team should be treated with dignity and respect. Applying the title of Dr is not necessarily an appropriate solution to placate concerns of treatment otherwise. It is confusing and misleading to patients and likely would not solve the underlying issue that seems to be driving this proposed change.