March Council Meeting

Friday, March 13th, 2020 | 8:00 a.m. |

AGENDA

Time		Item		Page Number
5 min	8:00 am	**1.**	Opening Remarks	-
0 min	8:05 am	**2.**	Agenda – Approval	-
		3.	Call for Conflict of Interest	
		4.	In Camera (if needed)	
5 min	8:05 am	**5.**	Council Meeting Minutes – For Approval – i. December 13th, 2019 Council Minutes	**2**
60 min	8:10 am	**6.**	Standard of Practice for Prescribing Benzodiazepines – For Approval	**8**
30 min	9:10 am	**7.**	Standard of Practice/Practice Directions	
			i. Standard of Practice –Seatbelts/Helmets – For Approval	**18**
			ii. Practice Direction – EKG Interpretation & Billing Eligibility – For Approval	**19**
			iii. Standard of Practice – Out of Hospital Births – For Information	**21**
25 min	9:40 am	**8.**	Future of QI Committee – For Approval	**37**
20 min	10:05 am	**9.**	**--Break—**	
30 min	10:25 am	**10.**	Strategic Organizational Priorities Update – For Information	**41**
			i. Standard of Practice for Authorizing Cannabis	**44**
			ii. Standard of Practice Boundary Violations	**45**
			iii. Non-Hospital Medical or Surgical Facilities Accreditation Criteria	**46**
10min	10:55 am	**11.**	Privacy Policy – For Approval	**48**
5 min	11:05 am	**12.**	Appointment of Public Representatives – For Approval	**56**
20 min	11:10 am	**13.**	Registrar's Report	**58**
20 min	11:30 am	**14.**	Committee Reports (written, questions taken) – For Information i. Executive Committee ii. Audit & Risk Management Committee iii. Complaints Committee iv. Investigation Committee v. Program Review Committee vi. Quality Improvement Committee vii. Central Standards Committee	**70**
15 min	11:50 am	**15.**	In Camera	

Meeting of Council, December 13, 2019

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Friday, December 13, 2019 at the College offices, 1000-1661 Portage Avenue, Winnipeg, Manitoba.

1. CALL TO ORDER

The meeting was called to order at 8:00 a.m. by the Chair of the meeting, Dr. Ira Ripstein.

PRESENT:
Ms Leslie Agger, Public Councillor
Dr. Kevin Convery, Morden
Dr. Heather Domke, Winnipeg
Dr. S. Jay Duncan, Brandon
Dr. Jacobi Elliott, Grandview
Mr. Allan Fineblit, Public Councillor*
Dr. Brent Kvern, Winnipeg
Dr. Daniel Lindsay, Selkirk
Dr. Matthew MacDowell, Assoc. Member
Ms Lynette Magnus, Public Councillor
Dr. Wayne Manishen, Winnipeg
Ms Marvelle McPherson, Public Councillor
Dr. Brian Postl, Winnipeg
Dr. Ira Ripstein, Winnipeg
Dr. Nader Shenouda, Oakbank
Dr. Eric Sigurdson, Winnipeg
Dr. Josef Silha, Winnipeg (8:25 a.m.)
Dr. Heather Smith, Winnipeg
Dr. Roger Süss, Winnipeg
Dr. Alewyn Vorster, Treherne
Dr. Anna Ziomek, Registrar

REGRETS:
Dr. Brian Blakley, Winnipeg

ABSENT:
Dr. Ravi Kumbharathi, Winnipeg

TELECONFERENCE:
Ms Dorothy Albrecht, Public Councillor
Dr. Brett Stacey, Flin Flon

STAFF:
Dr. Terry Babick, Deputy Registrar
Ms Kathy Kalinowsky, General Counsel
Ms Lynne Leah, Executive Assistant
Ms Karen Sorenson, Executive Assistant
Dr. Garth Campbell, Medical Consultant
Mr. Dave Rubel, Chief Operating Officer
Dr. Karen Bullock Pries, Assistant Registrar
Dr. Marilyn Singer, Quality Improvement
Dr. Ian Wilkinson, MANQAP*
Dr. Marina Reinecke, Medical Consultant*
Dr. Kernjeet Sandhu, Medical Consultant*

* only attended part of the meeting

2. ADOPTION OF AMENDED AGENDA

IT WAS MOVED BY DR. ERIC SIGURDSON, SECONDED BY DR. ROGER SÜSS:
CARRIED

That the agenda be approved.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

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

4. ADOPTION OF MINUTES

IT WAS MOVED BY MS MARVELLE MCPHERSON, SECONDED BY DR. ERIC SIGURDSON:
CARRIED

- That the minutes of the September 13, 2019 be accepted as presented.
- That the minutes of the September 27, 2019 electronic meeting be accepted as presented.

5. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

At the June 2019 Council meeting, Council directed the Registrar to establish Working Groups for several of the College's strategic organizational priorities. All Working Groups have met over the past three months and recognize that the public interest and patient safety are paramount. A brief verbal synopsis of the issues identified, and progress of the Working Groups was provided:

- Mr. Allan Fineblit, Chairperson: Boundary Violations – Sexual Involvement with a Patient
- Dr. Ira Ripstein, Chairperson: Standard of Practice for Prescribing Benzodiazepines
- Dr. Brent Kvern, Chairperson: Standard of Practice for Authorizing Marijuana
- Dr. Wayne Manishen, Chairperson: Non-Hospital and Surgical Accredited Facilities

6. GOVERNANCE REVIEW – RECOMMENDED CHANGES FOR QUICK FIXES

At its September meeting, Council provided direction to the Registrar on how to proceed with the recommended changes to the governance process. The principles of conflict of interest were reviewed to avoid conflicts of interest with Doctors Manitoba and ensure CPSM acts completely within its mandate of serving and protecting the public interest.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRENT KVERN that:
CARRIED WITH ONE OPPOSED

i) Council Amend the Affairs of the College Bylaw by adding the following:

3. To be eligible to be a candidate for election as a Councillor, a regulated member must meet all of the following requirements:
    e. not be a current member of the Board of Directors of Doctors Manitoba.
36. An elected Councillor or a Councillor appointed by Council ceases to hold office if the Councillor:
    h. becomes a member of the Board of Directors of Doctors Manitoba.

ii) Council Amend the Affairs of the College Bylaw by deleting and adding the following:

52. All voting at Council and Committee meeting is open. Voting for the position of president-elect may be conducted by secret ballot if requested by any councillor.

iii) Council Amend the Governance Policy Terms of Reference of the Quality Improvement, Maternal and Perinatal Health Standards, and Child Health Standards Subcommittees to include:

4.15.1.b.ii One of the subcommittee members will be the Chair of the Central Standards Committee as ex officio and non-voting member.

4.15.2.b.ii One of the subcommittee members will be the Chair of the Central Standards Committee as ex officio and non-voting member.

4.15.5.c. i.7 The Chair of the Central Standards Committee as ex officio and non-voting member.

7. SELF-EVALUATION OF COUNCILLORS

At the September Council meeting, the Registrar was directed to revise the current self-evaluation form. The new evaluation of Council form was completed. At the March 2020 Council meeting, every councillor will be asked to complete the form and a couple speak to their evaluations.

8. REPORT ON CHIEF MEDICAL EXAMINER'S REFERRALS ON PRESCRIBING

Dr. Marina Reinecke and Dr. Kernjeet Sandhu presented on the College's work from the Adult Inquest Review Committee of the Chief Medical Examiner to review all deaths involving prescription medications. These reviews indicate that stimulant-related deaths are climbing rapidly while opioid deaths have levelled off. Alprazolam and Gabapentin, as well as diphenhydramine, have become significant drugs of abuse in Manitoba. A very robust question and answer session followed on the importance of this work for patient safety. The Standard of Practice for Prescribing Benzodiazepines is seeking to greatly improve prescribing practices to enhance patient safety.

9. STANDARDS OF PRACTICE AND PRACTICE DIRECTIONS – ONGOING REVIEW – 4 YEAR CYCLE

The Standards of Practice and Practice Directions have been in place for several years and have not been reviewed recently to determine ongoing relevance, best practices, and whether new standards are required to reflect changes in the practice of medicine and shifting societal norms. As a strategic organizational priority a four-year cycle has been created to review these.

10. CONTINUITY OF CARE

The College of Physicians & Surgeons of Ontario approved four inter-related *Continuity of Care* policies. Continuity of care is an essential component of patient-centred care and an

important contributor to patient safety and in the public interest. Council provided direction to place this onto the next list of Strategic Organizational Priorities for its decision.

11. CEO/REGISTRAR'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at the College. Dr. Ziomek spoke verbally to this report and answered the questions presented by the Councillors, including recent improvements to the disciplinary process in Ontario.

12. PRACTICING TELEMEDICINE IN NUNAVUT – MEMORADUM OF UNDERSTANDING

The Government of Nunavut and the CPSM have put into place a Memorandum of Understanding whereby Manitoba physicians may provide telemedicine services to patients in Nunavut without registration in Nunavut.

13. MANITOBA PRESCRIBING PRACTICES PROGRAM – PRACTICE DIRECTION MODIFICATION

Certain prescription drugs listed under the Manitoba Prescribing Practices Program (M3P) can only be prescribed on a College approved prescription form. These drugs are listed on Schedule A to the Manitoba Prescribing Practices Program Practice Direction, which is approved by Council. Xyrem is a known "date rape" drug and should be included in M3P for public safety.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SHENOUDA
CARRIED

That Council approve amending Schedule A to the Manitoba Prescribing Practices Program Practice Direction by removing Foquest from and adding Xyrem to the list of drugs covered by the Manitoba Prescribing Practices Program.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN POSTL
CARRIED

That Council approve amending the Practice Direction by:

1. deleting "residents, physicians, and clinical assistants" from #2
2. adding 2.1 "For outpatient prescriptions residents, physician assistants, and clinical assistants cannot prescribe M3P drugs as per the CPSM General Regulation."
3. deleting #6.7 "for residents, physician assistants and clinical assistants, the prescriber's supervising physician's name".

14. REPLACEMENT OF DEPUTY REGISTRAR TERM

Following the retirement of Dr. Terry Babick as Deputy Registrar, there will no longer be a Deputy Registrar. Instead there will be two Assistant Registrars. Dr. Bullock-Pries, the current Director of Complaints and Investigations will be an Assistant Registrar, as will Dr. Ainslie Mihalchuk.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY MR. ALLAN FINEBLIT
CARRIED

That the terms "Deputy Registrar" and "Director of Complaints and Investigation" be replaced with Assistant Registrar in all Bylaws, Practice Directions, and Policies of Council.

14. ACCREDITED FACILTIES BYLAW AMENDMENTS

To improve the qualifications of employees performing tests and enhancing the grounds for review in addition to other minor improvements to protect patient safety, this bylaw was amended as proposed in the following areas:

- 2.8 cooperate with MANQAP inspectors
- 2.17 accreditation status reviewed
- 4.2 and 5.2 variance and renewal of accreditation
- 7.8.7, 7.8.8, and 7.8.9 qualifications and competence of technologists
- and other minor areas.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN POSTL
CARRIED

15. COMMITTEE REPORTS

The following Reports were presented to Council for information:

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

16. In Camera Session

The President advised that Council directed that matters not be placed on the agenda after the materials have been sent unless absolutely urgent.

There being no further business, the meeting ended at 12:20 p.m.

_____
Dr. I Ripstein, President

_____
Dr. A. Ziomek, Registrar

COUNCIL MEETING – MARCH 13, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Standard of Practice for Prescribing Benzodiazepines and Z-Drugs

BACKGROUND:

Need for a Standard

There is a need for the CPSM to have a Standard of Practice for physicians who prescribe Benzodiazepines and Z-Drugs to patients.

The CPSM participates in the Adult Inquest Review Committee of the Chief Medical Examiner to review all deaths involving prescription medications. These reviews indicate deaths from other drugs are climbing rapidly while opioid deaths have levelled off. Alprazolam and Gabapentin, as well as diphenhydramine, have become significant drugs of abuse in Manitoba.

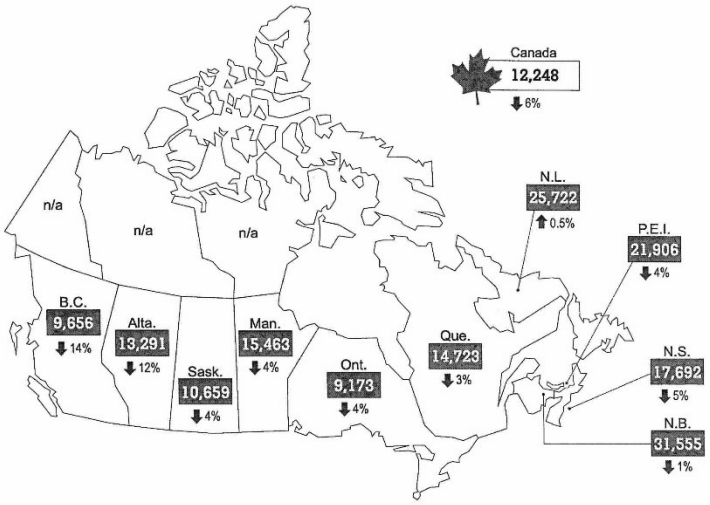
- Alprazolam is the benzodiazepine that contributed to the largest number of overdose deaths last year.
- Most opioid deaths can be attributed to one or more opioids combined with other drugs, often benzodiazepines and/or Z-Drugs.
- The two drug classes that were the top contributors to opioid overdoses were benzodiazepines and antidepressants from 2014-2017.
- Alprazolam, Zopiclone, and/or SSRIs contributed in total to 11, 9, and 8 drug overdose deaths respectively from 2016-2018.

The lessons learned from this provincial death data should transform physician prescribing practices. The Standard is to urge physicians to be mindful of polypharmacy - the overall risk may outweigh the benefit from individual medications. Opioids, benzodiazepines, antidepressants, Z-Drugs, antipsychotics, and gabapentin all interact with each other often contributing to these deaths.

Outside of Atlantic Canada, Manitoba has the highest rate of prescribing benzodiazepines and related drugs, at 50% higher than neighbouring Ontario and Saskatchewan. In 2017 there were 15,463 defined daily doses per 1000 population for these drugs

Pan-Canadian Trends in the Prescribing of Opioids and Benzodiazepines, 2012 to 2017

Figure 5 Defined daily doses per 1,000 population, Canada,* for benzodiazepines and benzodiazepine-related drugs, 2017



British Columbia and Alberta had the largest decreases in the rate of prescribed benzodiazepines and benzodiazepine-related drugs.

Notes
* Data was not available for the territories.
↓ ↑ Percentage change in prescribing from 2016 to 2017.
n/a: Not available.
Source
Prepared using data from CompuScript, IQVIA.

The Working Group

A Working Group composed of representatives from:

- College of Physicians &Surgeons of MB
- Psychiatry
- Addiction Medicine
- Geriatric Medicine
- Geriatric Psychiatry
- Family Medicine
- Rural and Northern Family Medicine Practices
- Manitoba College of Family Physicians
- College of Registered Nurses of Manitoba
- College of Psychiatric Nurses of Manitoba
- College of Pharmacists of Manitoba

The Working Group, chaired by Dr. Ira Ripstein, was convened to draft recommendations to Council by delivery of a draft Standard of Practice on Prescribing Benzodiazepines. The areas of specialty were chosen for their diverse knowledge of and clinical experience with these drugs. With this diversity in the Working Group it was understood that there would be differences of professional opinion.

The Working Group met on several occasions and reviewed drafts of this Standard of Practice. The members of the Working Group were very active in their participation and passionate in expressing their opinions professionally. Differences of opinion arose, partially along the lines of practices. The Standard is so much stronger and a much better document having heard and received input from the diverse professionals.

The Standard

This draft Standard does not address prescribing for palliative or end-of-life patients, acute seizure disorders, akathisia, and alcohol withdrawal. The Working Group viewed treatment of these medical conditions as so specific they did not warrant inclusion in the Standard of Practice.

Although the Terms of Reference were to develop a Standard of Practice for Prescribing Benzodiazepines, one of the first decisions of the Working Group was to extend this beyond Benzodiazepines to also include what are known as the Z-Drugs (Zopiclone, Zolpidem, Zaleplon, and Eszopiclone) because of the similarity of these drugs in prescribing for similar medical conditions, risks, addictions (abuse and diversion), and use.

Benzodiazepines and Z-Drugs have been identified as potentially inappropriate medications for use in older adults and carry significant risk such as:

- Sedation, confusion, drowsiness and postural instability contributing to the risk of falls and subsequent fractures;
- Impairment of psychomotor skills, judgment, and coordination increasing the risk of motor vehicle accidents;
- Negative effects on cognition and memory, delirium, drug-related pseudo dementia and a possible link to cognitive decline and Alzheimer's disease;
- Dependency and abuse potential;
- Risky interaction with medications or herbals;
- Sleep automatism (in the case of Z-Drugs), including food binging, and even driving while asleep or in a sleep-like state. See the Alberta College's Clinical Toolkit: http://www.cpsa.ca/wp-content/uploads/2017/06/Benzodiazepine-Clinical-Toolkit-Use-and-Taper.pdf

A study in Manitoba in 2016 concluded that a limited segment of the population that received benzodiazepine prescriptions was classified as sustained users, and a smaller proportion of that group escalated to doses higher than those recommended by product monographs and clinical guidelines. https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500380

Drugs of dependence have important therapeutic uses, but there is a need to ensure the supply of these medicines is clinically appropriate. The Standard tries to strike the best balance between the benefits benzodiazepines provide for many patients with the risk posed to some patients. The Working Group was assisted in achieving this balance by reliance upon the newly issued Deprescribing Benzodiazepine Receptor Agonists: Evidence Based Clinical Practice Guideline issued by the College of Family Physicians of Canada which is referenced in the Standard. https://www.cfp.ca/content/64/5/339

The Working Group was also aided by the 2015 publication of the Prescribing Drugs of Dependence in General Practice Part B, by the Royal Australian College of General Practitioners which has created a framework for accountable prescribing of benzodiazepines in a practical guide family physicians can use to minimise harm and maximise benefits to patients. There are terrific resources included such as examples of responses to patient requests for benzodiazepines, communications with patients, practice policies and forms, drug and alcohol assessment tool, and a GP Guide to insomnia.
https://www.racgp.org.au/download/Documents/Guidelines/Opioid/Opioid-Guide-Summary.PDF

When CPSM releases the Standard of Practice numerous resources to assist both physicians and their patients will be provided.

Use of the Standard

As a Standard of Practice, this is a mandatory requirement of expected conduct of all members. Standards of Practice are normative, describing how a practitioner is to practice, at a minimum, as evidenced by their observable behaviour and actions. The Standard uses the language of "must" which is imperative, rarely the permissive "may". The Standard is established to regulate the quality of practice by the members of the CPSM. The Standard will be used to assist members in their practice. Additionally, the Standard will be used for assessing physician performance in peer review processes or in complaints and investigations.

Consultation

All Standards of Practice are distributed to the membership, stakeholders, and the public for consultation. Input will be sought and may be incorporated by Council prior to adoption. At this point, approval is being sought to distribute this Standard and seek consultation with the membership.

It is expected the consultation will elicit significant interest amongst many physicians and likely similar diverse professional opinions will arise as were evident in the Working Group. It is also expected this document will have a direct impact not only on how some physicians prescribe benzodiazepines and Z-Drugs, but also on patient care for some of those patients.

PUBLIC INTEREST RATIONALE:

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

The section at the beginning on the need for a Standard of Practice also forms part of the public interest. The arrival of benzodiazepines into clinical practices in the 60s was met with enthusiasm – these drugs permitted doctors to offer patients a class of medication with many properties (sedative, anxiolytic, anticonvulsant, muscle relaxation) at a time when there were few effective therapeutic alternatives. These were prescribed for anxiety, depression, insomnia, mental illness, and neuromuscular conditions. By the 70s they were the most commonly prescribed drugs in the world. In 1978 more than 2.3 billion doses of diazepam (Valium) were sold in the US alone.

By the 80s, evidence of the addictive nature of benzodiazepines grew and it became generally accepted benzodiazepines brought their own problems. Benzodiazepines remain a major anxiolytic therapy and not just for short term use. There is growing apprehension regarding the harms associated with the sanctioned and unsanctioned use of benzodiazepines. The misuse of Alprazolam is particularly problematic and appears to be disproportionately associated with misuse, fatal and non-fatal overdoses, paradoxical excitation, and withdrawal and rage responses, as well as traffic accidents and crime-related harms.

In the past two decades clinical guidelines have recommended against long-term use of benzodiazepines and Z-Drugs and health agencies worldwide have undertaken, with some controversy, "anti-benzodiazepine" campaigns. However, it appears such recommendations have not had a significant impact on the use of these drugs. Major concerns are related to the development of tolerance, dependence, and addiction.
https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500380

The conditions where benzodiazepines are most commonly prescribed (anxiety and insomnia) remain sources of debate in medical circles. Physicians must consider multiple factors when prescribing benzodiazepines. Good clinical judgment and an evidence-based approach remain key to safe and appropriate prescribing. This Standard will set CPSM's minimum requirements for all physicians prescribing benzodiazepines and Z-Drugs and ensure prescribing when clinically indicated.

(The first two paragraphs are largely taken and adapted from the Royal Australian College of General Practitioners 2015 publication, Prescribing Drugs of Dependence in General Practice.)

RECOMMENDATIONS:

The recommendations of the Working Group are for Council to:

1. Approve the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs, as attached, for distribution and consultation with the membership, stakeholders and the public.
2. Include Benzodiazepines and Z-Drugs in the list of M3P Drugs, in conjunction with the College of Pharmacists of Manitoba.
3. Recommend to the Monitored Drug Review Committee that Alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary.

MOTION

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

Council hereby approve the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs for distribution and consultation with the membership and stakeholders.

DRAFT FOR COUNCIL

Schedule N - Prescribing Benzodiazepines and Z-Drugs

(including Zopiclone and other drugs)[1]

PREAMBLE

This Standard establishes the standard of practice and ethical requirements of all members in relation to prescribing benzodiazepines and/or Z-Drugs for maximum safety for all patients whether in the community or in a health care facility. **This Standard does not apply to the use of these drugs in the treatment of palliative and end-of-life patients, acute seizure disorders, bipolar/psychotic disorder, and alcohol withdrawal.** Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs is altered over time, so prescribing these drugs must be in accordance with current medical knowledge. These drugs are a known major contributor to a significant number of prescription medication-related deaths including opioids, especially due to polypharmacy, in Manitoba. This Standard recognizes that:

- Every member is professionally responsible for each prescription the member provides to the patient.
- In prescribing benzodiazepines and/or Z-Drugs each member provides their clinical judgment, which is to be that of a member acting reasonably in the circumstances with current medical knowledge.
- Initiating benzodiazepines and/or Z-Drugs in hospital substantially increases the risk of long-term use and dependency.
- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.
- The number needed to treat with a benzodiazepine and/or Z-Drugs to get improved sleep is 13, whereas the number needed to harm is only 6.

STANDARD OF PRACTICE

1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

2. To mitigate risk of harm the member must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations, and will prevent patients from obtaining prescriptions from multiple providers.

[1] See Table near end for drugs included in this Standard.

3. Members must prescribe the lowest effective dosage of benzodiazepines or Z- Drugs for the shortest possible duration and only exceed the maximum recommended dosage in exceptional circumstances.

4. Long term use must be supported by current clinical evidence indicating that benzodiazepines and Z-Drugs may be appropriate for certain patients.

5. Discuss the following with the patient and document it in the medical record:
    a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;
    b. Non-pharmacological therapies;
    c. The benefit of long-term benzodiazepines and Z-Drugs treatment is modest;
    d. Risks; and
    e. These drugs cause impairment. Advise them of the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired.

6. Appropriate use must be discussed with the patient with explicit instructions on the quantity and anticipated days supply, which must be noted on the prescription in the form of a dispensing interval.

7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:
    a. For patients in remote communities; and
    b. For patients travelling, if the patient has been on a stable long-term prescription.

8. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, if in exceptional circumstances considering a start, the member must have extremely strong current clinical evidence. A new start for Alprazolam must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If not replaced, then document why not possible.

9. Members must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:
    a. Heart failure, obesity, sleep apnea, chronic lung disease, and renal or hepatic insufficiency and other chronic conditions or pregnancy compound the risk of these medications in unique ways.
    b. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood disorders) which may complicate management.

c. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient's care needs. Appropriate care management can include referral to a physician with expertise and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal and does not include abruptly discontinuing these drugs.

10. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:
    a. Determine the lowest effective dose of benzodiazepines and/or Z-Drugs needed to achieve or maintain the treatment goals and periodically consider a trial of slow tapering. Use tapering guidelines and equivalency tables attached to this Standard of Practice. Where tapering is not feasible, if there is documented benefit to the patient, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is very difficult, though not impossible.
    b. If prescribing benzodiazepines and/or Z-Drugs, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications.
    c. Physicians must exercise caution in prescribing these drugs with muscle relaxants, sedating antidepressants, anticonvulsants, antipsychotics and other sedating medications.
    d. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.
    e. Only in exceptional circumstances prescribe opioids together with benzodiazepines and/or Z-Drugs. Patients must be informed of the increased risk of death with this combination, and the discussion documented.
    f. Only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper.

OLDER ADULT PATIENTS

11. Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

12. For older adult patients recognize that new starts of benzodiazepines and Z-Drugs must be carried out with extreme caution and not be used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium.

13. Ensure that dosaging takes into consideration declining renal, hepatic and cognitive function in older adult patients.

14. In prescribing for older adult patients, the member must recognize and discuss with the patient additional risks, including but not limited to:
    a. Falls and subsequent fractures related to sedation, confusion, drowsiness and postural instability;
    b. Impairment of psychomotor skills, judgment, and coordination increases the risk of motor vehicle and other accidents;
    c. Negative effects on cognition, memory, delirium and a possible link to cognitive decline and dementia.

APPLICABLE DRUGS FOR THIS STANDARD

Benzodiazepines		Z-Drugs
Alprazolam (Xanax®)	Lorazepam (Ativan®)	Eszopiclone
Bromazepam (Lectopam®)	Midazolam (Versed®)	Zaleplon
Chlordiazepoxide (Librium®)	Nitrazepam (Mogadon®)	Zolpidem
Clobazam *to be started by Neurologists only	Oxazepam (Serax®)	Zopiclone
	Potassium-Clorazepate	
Clonazepam (Rivotril®)	Temazepam (Restoril®)	
Diazepam (Valium®)	Triazolam (Halcion®)	
Flurazepam (Dalmane®)		

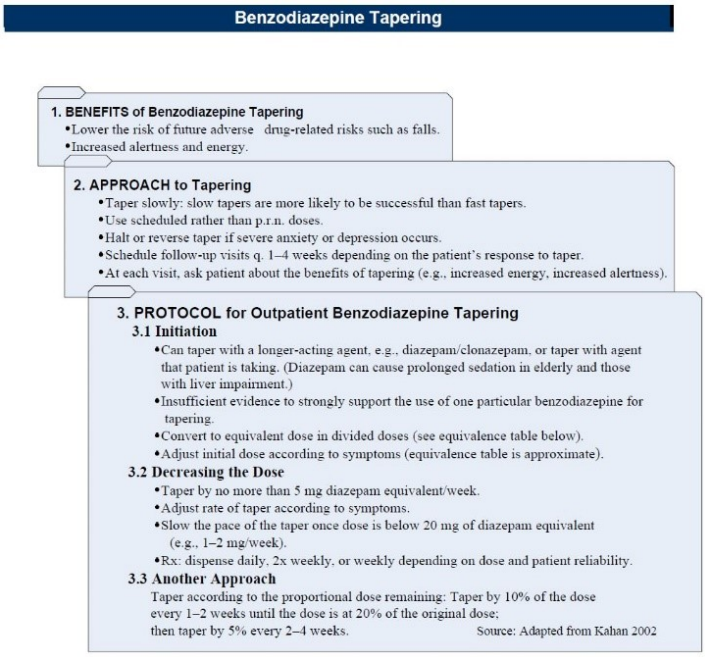
BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES

(Diazepam 10 mg as reference)

	Ashton	Kalvik et al.	Shader & Greenblatt	Alessi-Severini et al.
Diazepam	**10 mg**	**10 mg**	**10 mg**	**10 mg**
Alprazolam (Xanax®)	0.5 mg	1 mg	1 mg	1 mg
Bromazepam (Lectopam®)	5 mg	6-12 mg	NA	10 mg
Chlordiazepoxide (Librium®)	25 mg	20-50 mg	50 mg	20 mg
Clobazam	20 mg	NA	NA	20 mg
Clonazepam (Rivotril®)	0.5 mg	1-2 mg	0.5 mg	0.5 mg
Potassium Clorazepate	15 mg	15 mg	15 mg	NA
Flurazepam (Dalmane®)	30 mg	30 mg	30 mg	30 mg
Lorazepam (Ativan®)	1 mg	1-2 mg	2 mg	2 mg
Oxazepam (Serax®)	20 mg	30 mg	30 mg	20 mg
Nitrazepam (Mogadon®)	10 mg	10-20 mg	10 mg	10 mg
Temazepam (Restoril®)	20 mg	20-30 mg	30 mg	30 mg
Triazolam (Halcion®)	0.5 mg	0.5 mg	0.25 mg	0.25 mg
Zaleplon	20 mg	NA	NA	20 mg
Zolpidem	20 mg	NA	10 mg	NA
Zopiclone	15 mg	NA	NA	7.5 mg

Ashton H. benzo.org.uk : Benzodiazepine Equivalence Table. http://www.benzo.org.uk/bzequiv.htm. Published 2007. Kalvik A., Isaac P., Janecek E. Benzodiazepines: Treatment of anxiety, insomnia and alcohol withdrawal. Pharmacy connection Sept/ Oct 1995 20-32. Shader RI, Greenblatt DJ. Can you provide a table of equivalences for benzodiazepines and other marketed benzodiazepine receptor agonists? *J Clin Psychopharmacol*. 1997;17(4):331. Alessi-severini S, Bolton JM, Enns MW. Sustained Use of Benzodiazepines and Escalation to High Doses in a Canadian Population. *Psychiatr Serv*. 2016;67(9):1012-1018.

TAPERING GUIDELINES



Canadian Guideline http://nationalpaincentre.mcmaster.ca/opioid/

COUNCIL MEETING – MARCH 13, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Standard of Practice – Seatbelts/Helmets

BACKGROUND:

CPSM is reviewing all Standards of Practice and Practice Directions over a four-year cycle.

CPSM is reviewing this Standard and requested feedback from Manitoba Public Insurance which indicated MPI was in support of retaining the Standard as is.

Legislation requires all motorcyclist must wear a motorcycle helmet unless they are a member of the Sikh faith or holds a certificate signed by a qualified medical practitioner certifying that the person is, during the period stated in the certificate, unable for medical reasons to wear a safety helmet.

The current Standard of Practice states:

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

It is recommended the current Standard of Practice be retained and slightly reorganized.

PUBLIC INTEREST RATIONALE:

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

There is no medical reason for providing an exemption to wearing a motorcycle helmet and significant evidence exists that motorcycle helmets provide safety to motorcycle riders.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The Standard of Practice for Seatbelt and Helmet Exemptions in Schedule C be approved as follows:

> No member of the CPSM should ever write a seatbelt or helmet exemption. Available and acceptable alternatives to non-use of a seatbelt include reconfiguration, use of padding or other accommodations. There are no medical conditions that justify exemptions from seatbelt or helmet use.

COUNCIL MEETING - MARCH 13, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Practice Direction – EKG Interpretation and Billing Eligibility

BACKGROUND:

Manitoba Health requires knowledge as to who is eligible to bill for interpreting EKGs. A number of different specialties, including family medicine, could be eligible and therefore Manitoba Health requested CPSM to provide names of eligible physicians. CPSM has for many years acted as the gatekeeper by permitting physicians who pass any of the listed exams to be entered on a list which permits such billing.

CPSM is reviewing all Standards of Practice and Practice Directions over a four-year cycle. CPSM is reviewing this Practice Direction and requested feedback from the following:

Department Head Cardiology, U of M
Department Head, Cardiology, St. Boniface Hospital
Medical Director of EKG, WRHA Cardiac Science Program
Chief Medical Officers of Shared Health and Regional Health Authorities
CPSM Assistant Registrars and Medical Consultants

All of the above provided comments in support of retaining the current Practice Direction.

It is recommended that the Practice Direction be approved, with only a minor change in its organization. It is recommended that no consultation be undertaken.

PUBLIC INTEREST RATIONALE:

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

Patients are served best when those with additional training interpret EKGs.

MOTION

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

The Practice Direction on EKG Interpretation and Billing Eligibility is approved as attached.

PRACTICE DIRECTION

EKG Interpretation and Billing Eligibility

Initial Approval: November 22, 2018 **Effective Date: January 1, 2019**

Reviewed and Revised
March 13, 2020

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

This Practice Direction is made under the authority of s. 85 of the RHPA.

The following is an area of practice that requires specific eligibility requirements prior to practice, pursuant to S. 3 and 5 of the Practice of Medicine Regulation.

This Practice Direction sets out the eligibility requirements to include adult EKG interpretation and billing within a physician's scope of practice, pursuant to s. 3 and 5 of the Practice of Medicine Regulation.

1. All physicians except those approved, as of January 22, 2003, to read adult EKGs and bill for adult EKG interpretation who are deemed to have met the eligibility requirements, must meet the following criteria applied by the Registrar for approval to read adult EKGs and bill for adult EKG interpretation:
   - 1.1. Certificants of the Royal College of Physicians & Surgeons of Canada in Adult Cardiology or who hold the certificate of special competence in Adult Cardiology; or
   - 1.2. Specialist training in Adult Cardiology acceptable to the College; or
   - 1.3. Successful completion of an EKG examination conducted by one of the following organizations:
     - 1.3.1. the University of Manitoba;
     - 1.3.2. the College of Physicians and Surgeons of Saskatchewan;
     - 1.3.3. the American College of Cardiology;
     - 1.3.4. the American Board of Internal Medicine Cardiovascular Disease;
     - 1.3.5. the Institute for Clinical Evaluation (U.S.);
     - 1.3.6. the College of Physicians and Surgeons of Alberta; or
     - 1.3.7. any program offered by a Canadian medical regulatory authority if the Registrar is satisfied, based on reasonable evidence, that the program complies with appropriate standards.

COUNCIL MEETING - MARCH 13, 2020

ITEM FOR INFORMATION

SUBJECT:

Standard of Practice of Medicine - Home Births

BACKGROUND:

CPSM is reviewing the Standards of Practice of Medicine over a four-year cycle. This is the current Standard of Practice on Home Births.

1. Members must not have planned involvement in a home birth (i.e. outside of a hospital with obstetrical care)
2. When a member is consulted by a pregnant woman who intends to give birth at home, the member must:

   (a) Encourage appropriate prenatal and postnatal care for the mother and baby;

   (b) Identify to the patient the risks of home delivery for both mother and infant, and issues of postnatal care (e.g. Vitamin K prophylaxis, eye care, metabolic screening);

   (c) Familiarize the patient with emergency services available in the community; and

   (d) Document discussions with the patient on the foregoing points.

CPSM requested feedback from the following:

Department Head OB/GYN, University of Manitoba
Chair, Maternal & Perinatal Health Standards Subcommittee
Registrar, College of Midwives of Manitoba
Registrar, College of Registered Nurses of Manitoba
Chief Medical Officers of Shared Health and all Regional Health Authorities
Head, Neonatal-Perinatal Medicine
CPSM Medical Staff

Attached, for your review, are the comments received. There is no recommendation included. We ask that Councillors provide their opinions at the meeting. This is for information only with a recommendation the updated Standard be prepared for review at the June Council meeting.

The Society of Obstetricians and Gynecologists of Canada released a Clinical Practice Guideline in 2019, Statement on Planned Homebirth, as attached.

The Chair of the CPSM Maternal and Perinatal Standards Committee provided a detailed submission, along with a subsequent submission, also attached.

Comments

Department Head OB/GYN, University of Manitoba

I believe this Standard of Practice is correct.

WRHA Department Head of Obstetrics Gynecology and Reproductive Sciences

Medical Director, Women's Health Program

Most physicians will not want to participate in home births, and if they do decide to would need to acquire the special equipment to take to home births. Would also need to be up to date on NRP protocols - most of us are not as we never get our hands on a baby in a tertiary care center. There is no national policy prohibiting physicians at home births, my one concern would be the slippery slope in relationship to the birth center for example when a woman delivers at the birth center there is additional team members who would also come including a second midwife, so many issues to be sorted out if that happens. The Chair of the Maternal and Perinatal Standards Committee is one of the few obstetricians that would be in support of physician participation in home births, most of us would not want to participate. Poor outcomes when ambulance transport is not prompt is a reality and a risk that the patient has to accept when doing home birth. This has been reviewed in the department as it would trigger a standards committee review.

Neonatal-Perinatal Medicine Department Head

The Chair of the CPSM Maternal and Perinatal Standards Committee's recommendations are thorough and supported by evidence which he has provided in the document. I support their recommendations and don't believe I could add anything to what they have already stated.

College of Midwives of Manitoba

Thank you for reaching out. I'm happy to provide you with my thoughts. I appreciate that there has been a slow but measurable shift in the availability of midwifery care and its integration into the health care system in the past 20 years, which affects some of the direction provided in your current Standard.

I have provided some initial thoughts (and some questions) in blue below and am happy to provide further comment or clarification or discuss by telephone (or in person) if you like.

When considering my comments below I wrote them from the perspective that the CPSM would maintain the status quo re: physicians not attending home births. If this aspect may change, then it may be worth having a conversation. I know Ontario and BC (and maybe others) have removed the restriction, so I wasn't sure is CPSM was considering that as well.

Also, in our own documents we have moved away from 'home birth' to 'out-of-hospital' birth, which includes the birth centre (and in theory may include some hospitals/health centres). Not sure if this change in terminology would be helpful to you or not.

Thanks again and I look forward to further conversation.

College of Registered Nurses of Manitoba

The CRNM's position on the practice of a Registered Nurse related to management of labour and delivery is articulated in the Regulated Health Professions Act, College of Registered Nurses of Manitoba General Regulation Section 3.4 (43), which states, "*reserved act 14: A registered nurse may manage labour or the delivery of a baby within a facility where labour and delivery services are provided*". The Birth Centre would fit this definition of a facility.

Further, the Standards of Practice Section 4.2(5) state "*When engaging in the practice of registered nursing in a clinical practice setting a member must provide nursing care that includes …f) support for the client in self-management of their health care by way of the provision of information, resources and referrals to enable informed decision making by the client or his or her representative."*

The College would interpret this standard and reserved act to mean that an RN would be able to participate in the care of a client in a Birthing Centre, but not in a client's home, unless it was an emergency situation where no safe alternatives for transfer of care. Furthermore, that the RN would provide information to the client regarding a home birth within their knowledge and ability, and/or refer them to a member of the healthcare team who would be able to provide this information.

There are, therefore, inherent differences in the standards of the two Colleges related to the practice of physicians and registered nurses in home births. If you have any further questions regarding RN practice related to a home birth, please don't hesitate to contact us.

Responses from CMOs

The CMOS generally supported the current prohibition on physicians participating in home births overall and indicated that no physicians in their regions were performing out of hospital births.

Jurisdictional Scan

The Colleges of Ontario, Saskatchewan, Alberta, British Columbia, and Nova Scotia do not have a prohibition on physicians participating in home births.

College of Physicians and Surgeons of Ontario
The CPSO issued this explanation to the medical profession when its previous prohibition on Home Births policy was rescinded in 2001.

> **Home Births Policy Rescinded**
>
> Council has voted to rescind a seven-year-old policy that discouraged doctors from attending home births. The decision to revoke the policy was made after considering changes in the current regulatory environment and a review of current scientific literature.

In 1994, the College took the position that home births were not a safe alternative to hospital births and discouraged Physicians from attending them.

However, midwifery is now a regulated health profession with an established college, which has developed appropriate standards of care. These standards include guidelines for the transfer of patient care to a physician when clinical findings indicate it is necessary to do so. The option of having a birth at home has also become more common and more widely accepted. The practice has evolved since the early 1990s to the extent that a planned home birth for low-risk women is a viable, if not widely practised, birthing option.

A review of the current scientific literature indicates that there is no compelling evidence either supporting or opposing planned home births for low-risk patients. "There just does not appear to be a need to treat low-risk home births differently than any other medical procedure," said Dr. Rachel Edney, a councillor and member of the group which reviewed the policy. Council made it clear that any physician who chooses to attend planned home births will still be subject to the standard of care.

January 31st, 2020

Dr. Anna Ziomek, Registrar/CEO
College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Avenue
Winnipeg, MB R3J 3T7

Dear Dr. Ziomek:

RE: CPSM Standard of Practice of Medicine – Home Births

Thank you for your email you sent me on January 23rd, 2020 regarding updating the CPSM Standard of Practice on Home Births. I thank you for sending me the previous iteration of that standard. As requested I am proposing an updated and revised Standards of Practice in the provision of care for out-of-hospital birthing listed at the end of this mailing.

There is no doubt that opinions on birthing in an out-of-hospital (home or a birthing centre) is evolving in Canada. The rate out-of-hospital births is rising in Canada, mostly attributed to the availability of regulated midwifery services, an innate desire by women for low intervention, and the perceived comforts of home[1]. In the past two decades, several European publications mostly from Northern Europe and the UK have attested to the maternal and perinatal safety of out-of-hospital birthing in highly selected patients at low risk. Most provinces in Canada including Manitoba have regulated midwifery services which provide for out-of-hospital birthing. In the past two years two major documents, one from British Columbia and the other from Ontario[2, 3], were released comparing the experience and the maternal and perinatal outcomes of pregnant women who delivered out-of-hospital vs. in-hospital by regulated midwives. These data sets showed that in the highly selected pregnancy at no identifiable risk, who goes into spontaneous labour, and cared for by skilled providers (midwives in this context), and in the context of interprofessional collaboration and communication in a system that supports timely referral and full access to hospital obstetrical services should a transfer to a hospital be required, the maternal and perinatal outcomes were similar and in many aspects better in favour of out-of-hospital attempt at delivery.

From the BC and Ontario Midwifery Database it was evident that such supported out-of-hospital birth for these women at low risk have a higher spontaneous vaginal birthing rate (91% vs 86%, RR 1.06, CI 1.05-1.07), less inductions of labour (6.4% vs 19%, RR 0.61, CI 0.58-0.65), less pharmacologic pain relief administered (16% vs 43%, RR 0.38, CI 0.37-0.39), less episiotomy and sphincter injuries (the latter 1.4% vs 2.4%, RR 0.58, CI 0.49-0.65), less instrumental birth (3.1% vs 5.5%, RR 0.56, CI 0.53-0.63), less cesarean sections (5.8% vs 8.6%, RR 0.68, CI 0.65-0.74) and less infections (0.7% vs 3.5%, RR 0.2, CI 0.08-0.49). Equally there were no differences in stillbirth or neonatal death rates (1.1/1000 vs 0.9/1000, RR 1.26, NS) by 7 days of age and 28 days of age. There were no differences in low Apgar scores, admission to NICU (1.5% vs 1.7%, RR 0.89, CI 0.68-1.16) or severe adverse neonatal outcomes.

These outcomes described in the Canadian studies are quite similar to the outcomes from the Netherlands where an analysis of 743,070 pregnancies at low risk intended home births vs intended hospital births were analyzed.

Yet studies from the USA and from other countries that do not meet Canadian midwifery standards that incorporates skilled midwives, integrated system approach based on respect, communication, and timely emergency support in hospital for attempted home births, documented increased neonatal mortality and morbidity[4, 5, 6, 7, 8].

One would argue that there are no randomized clinical trials to date on the issue of home vs. in-hospital births. The above evidence tends to be retrospective in nature and hence subject to the effects of confounding factors and bias, complicated by the lack of matching, and analysis by intention to treat. However, one cannot but realize that the overall trend in the highly selected patients at low risk managed in an integrated system approach, the outcomes for out-of-hospital births are not worse, and in some aspects may in fact be better than in-hospital births.

The College of Physicians and Surgeons of Manitoba in its directives to physicians should stress to physicians to recognize and respect the importance of choice for women in the birthing process. Unfortunately there are currently no physicians in this province who have been certified in home birth skills. Midwifery in Manitoba on the other hand is well developed and integrated in the delivery of maternity care. Examples of excellent collaboration between midwives and physicians are rampant at the tertiary centres. But we do live in a country of vast open spaces, inclement weather, and absence of expertise in home birthing by physicians. The College of Physicians and Surgeons of Manitoba Maternal Perinatal Standards Committee has reviewed a few cases of poor outcomes for patients who attempted delivery out-of-hospital. Most of these poor outcomes were attributed to errors in judgement by the healthcare workers and delays in timely transportation to hospitals. I must admit, however, that the scene is improving.

Based on all the above, I would respectfully suggest that for Schedule B – Home Births ***(I would suggest we replace the words 'Home Births' by 'out-of-hospital births')***, the following be adopted:

1. *Members must recognize and respect the importance of choice for women and their families in the birthing process.*

2. *In the absence of specialized training for physicians in the provision of home births, members must not electively attend to labour and delivery outside a hospital setting.*

3. *Members when consulted by patients for home births must:*

    a. *Evaluate the patient for any apriori identified risks for which hospital delivery is advised,*

b. *Explore the reasons for the patient's choice in selecting an attempt for home birthing and counsel the patient accordingly,*

c. *Members must discuss with the patient the potential benefits based on available evidence, but more importantly discuss the risks and disadvantages of birthing out-of-hospital in this province. The aspects that should be discussed with the patient are the evidence that suggests that urgent intervention may be needed in 25% of patients who are identified at low risk. These interventions are needed due to acute and unforeseen labour progress issues, fetal intrapartum issues, hemorrhaging, cord prolapses, retained placenta, and pain control. Patients should understand that there is the occasional risk arising from delays in the transport to a hospital setting that may affect maternal and perinatal outcomes.*

d. *Members must familiarize patients identified apriori as being at no identified risk and who wish to explore the possibilities of delivery out-of-hospital, with midwifery services in this province. Midwives may help them in deciding whether or not out-of-hospital birthing may be provided or not based on criteria set by the College of Midwives Manitoba.*

e. *Patients should be encouraged to ensure appropriate prenatal and postnatal care under the care of certified maternity healthcare workers.*

f. *Patients should be advised of the important aspects of neonatal care (such as eye care, vitamin K prophylaxis, metabolic screens, detection and management of jaundice, vaccinations, fetal weight loss, breastfeeding issues, etc.)*

g. *Members should document discussions pertaining to the evaluation of patients, advice and counselling given. Documentation should include all aspects of prenatal and postnatal care provided by the physician.*

4. *Members must provide ethical, compassionate and appropriate care for patients who are attempting an out-of-hospital birth under the care of midwifery, but who needed to be transferred to hospital due to complications during the birthing process.*

5. *Members must be respectful and helpful to the healthcare worker/midwife who was involved in the care of a patient attempting an out-of-hospital birth upon the transfer of patient to the hospital for further care.*

I do hope the above directives will be acceptable to the officials and the Board of the College of Physicians and Surgeons of Manitoba.

If you wish to discuss any aspects of the above directives, please do not hesitate to get in touch with me.

Respectfully submitted,

Medical Advisor for the Maternal Perinatal Standards

College of Physicians and Surgeons of Manitoba

encl.

References

1. Society of Obstetricians & Gynaecologists of Canada. Policy statement on midwifery. J Obstet Gynaecol Can 2009; 31:662-3.

2. Better Outcomes Registry and Network Ontario. Data Analysis for Annual Report 2014-2016. Ottawa: Better Outcomes Registry and Network Ontario; 2016. Available at: https://www.bornontario.ca/assets/documents/Annual Report 2014-2016 Data Slides.pdf. Accessed September 4, 2018.

3. Perinatal Services BC. Midwifery Report: Deliveries in BC 2015/16. Vancouver: Perinatal Services BC; 2017. Available at: http://www.perinatalservicesbc.ca/Documents/Data-Surveillance/Reports/Special Reports/MidwiferyReport2015_16.pdf. Accessed September 4, 2018.

4. Grunebaum A, McCullough LB, Sapra KJ, et al. Apgar score of 0 at 5 minutes and neonatal seizures or serious neurologic dysfunction in relation to birth setting. Am J Obstet Gynecol 2013;209:323. e1-6.

5. Cheng YW, Snowden JM, King TL, et al. Selected perinatal outcomes associated with planned home births in the United States. Am J Obstet Gynecol 2013;209:325. e1-8.

6. Snowden JM, Tilden EL, Snyder J. Et al. Planned out-of-hospital birth and birth outcomes. N Engl J Med 2015;373:2642-53.

7. Grunebaum A, McCullough LB, Sapra KJ, et al. Early and total neonatal mortality in relation to birth setting in the United States, 2006-2009. Am J Obstet Gynecol 2014;211:390. e1-7.

8. Kennare RM, Keirse MJ, Tucker GR, et al. Planned home and hospital births in South Australia, 1991-2006: differences in outcomes. Med J Aust 2010;192:76-80.

February 9, 2020

Dr. Anna Ziomek, Registrar and CEO,
CPSM
1000-1661 Portage Ave
Winnipeg, MB R3J 3T7

Dear Dr. Ziomek,
Re: My recent letter on the CPSM standard of care regarding Out-of-Hospital Birthing

Further to my recent recommendations in updating the CPSM standard on "Home Birth" which I have submitted on January 31, 2020 upon your request, I am enclosing 4 copies (make more if needed) of the Society of Obstetricians and Gynecologists of Canada recent statement on "Planned Homebirth" dated February 2019, for your perusal and the perusal of the Board *(Ref. SOGC Statement No. 372-Statement on Planned Homebirth. JOGC, 2019 Pp 223-227)*

The Society of Obstetricians and Gynecologists of Canada is the national representative of the 12,000 + obstetrics and gynecology specialists in this country. Its membership also boasts more than 400 Women's Health nurses, midwives and all residents in training in Canada. As a member of the SOGC since 1983 and its Past President (2005-2006) I have served on almost all of its committees either as a member or a chair. I was a member of the Obstetrical Practice Committee when the above statement was approved by the committee members, the Council and the Board of the Society, and published in the Journal Obstetrics Gynecology Canada.

My recommended suggestions for standards for the CPSM on home-birth were based on the above document, personal review of the literature, availability of mandated midwifery that offers home birth for selected patients with pregnancies at no identified risks in Manitoba, and personal observations and discussions with colleagues in and out of this province.

The reason I am pointing this out is that few days ago I have been informed that my suggested recommendations have stirred a heated discussion in the recent meeting of the College. It appears that some were left with the impression that I did not agree with the previous CPSM standard. I wonder if I was misinterpreted regarding physicians' role, as this cannot be further from the truth and is not reflected in the recommendations I advised. In my career of 33+ years, I have been quite vocal about the perils of out-of-hospital birthing. In fact, in the CPSM Annual Report from the Maternal and Perinatal Morbidity and Mortality I write every year since 2007, I invariably present cases that reflect the perils of out of hospital birth. But there is a mandated role for trained midwives to practice out-of-hospital birthing in selected cases. For the safety of patients, the role of the physicians cannot remain prohibitive, but change to become educational, supportive to the midwife and patient in a hospital setting in a spirit of

understanding and respect. My suggestions do **NOT** propose that physicians go ahead and practice obstetrics in an out of a hospital setting.

But frankly I felt that the previous standard is brief and rigid and does not reflect the maternity care spirit of 2020 where the delivery of such care is multidisciplinary and team driven. Given the approved mandate by Manitoba Health of midwifery to offer out of hospital birthing, it also did not take into account patients' autonomy in choice, nor give specific directives to a physician when a patient seeks counselling about home births, nor does it address the role of the physician who only works in a hospital setting when faced by a referral or call from a midwife because of complications encountered while trying a home birth.

The current directives from our professional Societies and Colleges dictate that physicians are expected to practice in a manner that is based on recognition of patients' autonomy and respect for their choices, provision of counselling without coercion or bias, and the offering of physician ethically-driven safe medical health services that include full disclosure of risks and benefits in a context of social justice.

Hence there is a definite role for physicians in counselling patients prenatally on the risks of such an endeavour. But at the same time from an ethical point of view, and since counselling should never be coercive, this involves divulging to patients about the recorded and published outcomes from retrospective data analysis of birthing in an out-of-hospital settings. Part of the counselling however, is also to divulge to the patient in simple terms on the limitations of retrospective studies. Patients should understand that these studies involved "highly selected" low risk patient cared for by midwives in an environment of integrated system of back up with immediate transport to hospitals, and by availability of physicians to offer ethically-driven-medical help after the patient is transferred to a hospital setting. Physicians who get called by a midwife who seeks advice or help for a patient undertaking an attempted out of hospital birth should suggest the patient be transferred to hospital so that a physician may help.

I was not invited to the recent CPSM meeting when this standard was discussed, so I did not have a chance to clarify my points in person for the doubtful or the suspicious. I offer to discuss this further in person if you or the Board wish me to do so.

Hope you will share a copy of the SOGC statement with those who attended the meeting including the President, CPSM advisory lawyer and the Assistant Registrar.

Best regards,

It is SOGC policy to review the content 5 years after publication, at which time the document may be re-affirmed or revised to reflect emergent new evidence and changes in practice.

No. 372, February 2019

No. 372-Statement on Planned Homebirth

This Committee Opinion has been prepared by Clinical Practice Obstetrics and reviewed by the Guideline Management and Oversight Committee and approved by the Board of the Society of Obstetricians and Gynaecologists of Canada.

Kim Campbell, RM, Vancouver, BC

George Carson, MD, Regina, SK

Hussam Azzam, MD, Charlottetown, PE

Eileen Hutton, RM, Hamilton, ON

Clinical Practice Obstetrics Committee: Hussam Azzam, MD, Charlottetown, PE; Jon Barrett, MD, Toronto, ON; Melanie Basso, RN, Vancouver, BC; Hayley Bos, MD, Victoria, BC; Kim Campbell, RM, Vancouver, BC; Krista Cassell (Co-Chair), MD, Charlottetown, PE; Sheryl Choo, MD, London, ON; Gina Colbourne, MD, St. John's, NL; Kirsten Duckitt, MD, Campbell River, BC; Ellen Giesbrecht (Co-Chair), MD, Vancouver, BC; Michael Helewa, MD, Winnipeg, MB; Amy Metcalfe, PhD, Calgary, AB; Barbara Parish, MD, Halifax, NS; J. Larry Reynolds, MD, Winnipeg, MB; Yvonne Vasilie, MD, Pointe-Claire, QC

Disclosure statements have been received from the authors.

KEY MESSAGES

1. Registered Midwives and some physicians provide homebirth care in Canada.
2. The SOGC reaffirms and emphasizes the importance of choice for women and their families in the birthing process. The SOGC promotes well-integrated community and hospital birthing care to ensure safe maternal and newborn care.
3. In Canada, planning a homebirth with a registered midwife or an appropriately trained physician in the integrated system described is a reasonable choice for persons with low degree of risk where the birth is anticipated to be uncomplicated and neither mother nor neonate will require resources beyond the local capacity.
4. All pregnant women should receive information about the risks and benefits of their chosen place for giving birth and should understand any identified limitation at their planned birth setting. Risk assessments should be ongoing throughout pregnancy and birth and care providers must ensure the individual is advised of any change in their risk status to support their ability to make an informed choice for most suitable birth site.
5. Communication amongst and between the hospital and community obstetric teams using set standards supporting emergency transport are critical components of a seamless integrated system and should remain a priority in supporting best practice outcomes for planned homebirths.
6. The SOGC endorses evidence-based practice and encourages ongoing research into optimizing birthing outcomes in all birth settings. Prospective data collection should capture all births and include planned and actual place of birth.

J Obstet Gynaecol Can 2019;41(2):223–227

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All people have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice, patients should be provided with information and support that is evidence-based, culturally appropriate and tailored to their needs.

This guideline was written using language that places women at the centre of care. That said, the SOGC is committed to respecting the rights of all people – including transgender, gender non-binary, and intersex people – for whom the guideline may apply. We encourage healthcare providers to engage in respectful conversation with patients regarding their gender identity as a critical part of providing safe and appropriate care. The values, beliefs and individual needs of each patient and their family should be sought and the final decision about the care and treatment options chosen by the patient should be respected.

PLACE OF BIRTH

The SOGC Policy Statement on Midwifery states: "SOGC recognizes and stresses the importance of choice for women and their families in the birthing process. The SOGC recognizes that women want to choose the setting in which they will give birth. All women should receive information about the risks and benefits of their chosen place for giving birth and should understand any identified limitation of care at their planned birth setting. The SOGC endorses evidence-based practice and encourages ongoing research into the safety of birth settings."[1]

The SOGC values the importance of choice. Options may be limited, and sometimes plans may change. Decisions regarding place of birth must take into consideration available resources, the evolving health of mother and baby, and the mother's beliefs, values, and wishes. For example, some communities have no birth care providers; some have no midwives and few physicians who practice obstetrics offer homebirth services. Where midwifery is available, birthplace options may include home, free-standing birth centre, or hospital.

Out-of-hospital birth numbers are rising in Canada.[2,3] The increase may be attributed to the growth of available midwifery services, a desire for a low-intervention birth, and increasing comfort with birth outside of a hospital setting.[4] Canadian regulated health care providers, including Registered Midwives and physicians with specific expertise, may offer choice of birthplace as a standard of care within their jurisdictions. Registered Midwives in most jurisdictions in Canada are required to offer choice of birthplace for appropriately screened individuals who have a low degree of risk and where the birth is anticipated to be uncomplicated. Quality standards set by provincial and territorial regulators require Registered Midwives who attend homebirth to have hospital privileges, a second qualified care provider present at the birth, emergency equipment and supplies, and ongoing risk assessment and emergency transport protocols. Midwives in all regulated settings are publicly funded regardless of place of birth and are well integrated into the health care system. This team-based approach involves anticipatory planning in the event a transfer to hospital is necessitated.

Although safety of planned homebirth is debated in some jurisdictions, most notably the United States, many other settings such as the United Kingdom, The Netherlands, and New Zealand support this choice, as do Canadian provincial and territorial governments. For example, there are no regulatory restrictions on physicians in most Canadian jurisdictions for providing intrapartum care at home.[a] Randomized controlled trials have proven unfeasible due to lack of equipoise.[8–10] Publications are often difficult to compare as methodologies are complicated by lack of clarity on intended place of birth, risk status, standardization of provider qualifications or presence of qualified providers, appropriate comparison group, standardized language, accuracy of birth certificate data, accuracy of prospective data collection, and integration of homebirth providers into existing health care systems. To address these and other relevant issues, a systematic approach to appraise the quality of research on birth settings has been established.[11]

Findings from comparable universal health systems based upon the aforementioned criteria are helpful in providing outcomes that may be applicable to the Canadian homebirth context. Such findings include homebirth provided by regulated and integrated health care providers where transfer plans are pre-planned, and no punitive or financial disincentives exist for those transfers. Ideally, prospective data collection will reduce information bias; will accurately identify health care provider and risk assessment details in both home and hospital birth settings; will ensure appropriately matched comparison groups and standardized well-defined outcomes; and will ensure that the intended place of birth at outset of labour includes an intention-to-treat analysis. Considering these criteria and research from Canada and many similar settings, data support the safety of homebirth, with most studies reporting an association with improved maternal outcomes in low-risk pregnancies, including fewer interventions and complications.[12–30]

[a] At least 2 provincial physician regulatory colleges have removed restrictions from physicians attending homebirths. In 2001 the College of Physicians and Surgeons of Ontario rescinded their policy against physicians attending homebirths, stating that "there's no indication that a policy statement on homebirths is actually needed in the present-day environment (and) there is no need to separate homebirths from other medical procedures."[5] In 2009 the College of Physicians and Surgeons of British Columbia (CPSBC) rescinded its policy against homebirths.[6] In 2018, the CPSBC affirmed it "supports a woman's right to personal autonomy and decision making in obstetrical care and respects a physician's autonomy in their decision to offer home birth services to their patient."[7]

ABBREVIATIONS

CI	confidence interval
RR	relative risk
SOGC	Society of Obstetricians and Gynaecologists of Canada

Over the last 2 decades the Canadian experience with homebirth has been extensively studied. Outcomes in British Columbia and Ontario for 21 936 intended homebirths versus 23 508 intended hospital births, in which all births in both settings were attended by the same Registered Midwives, have been evaluated.[18–20,28] A meta-analysis of these 4 studies comparing outcomes for women planning homebirth with those planning hospital birth found a significant increase in spontaneous vaginal birth (91% vs. 85.9%; RR 1.06; 95% CI 1.05–1.07, $P < 0.00001$) and a significant reduction in interventions and maternal morbidity, including induced and augmented labour (6.4% vs. 19.1%; RR 0.61; 95% CI 0.58–0.65, $P < 0.00001$), pharmacologic pain relief (16.4% vs. 43.2%; RR 0.38; 95% CI 0.37–0.39, $P < 0.00001$), obstetric anal sphincter injury (1.4% vs. 2.4%; RR 0.58; 95% CI 0.49–0.65, $P < 0.00001$), episiotomy (4.1% vs. 6.1%; RR 0.68; 95% CI 0.62–0.74, $P < 0.00001$), instrumented birth (3.1% vs. 5.5%; RR 0.56; 95% CI 0.53–0.63, $P < 0.00001$), Caesarean birth (5.8% vs. 8.6%; RR 0.69; 95% CI 0.65–0.74, $P < 0.00001$), and infection (0.7% vs. 3.5%; RR 0.20; 95% CI 0.08–0.49, $P = 0.0005$).[31] Although postpartum hemorrhage occurred less often in those planning homebirth across studies, blood loss was measured differently, so the data were not pooled.

Outcomes of planned home births compared with planned hospital births attended by registered midwives in British Columbia and Ontario found no differences in intrapartum stillbirth and neonatal death in the first 28 days, excluding major anomalies (1.1/1000 vs. 0.9/1000; RR 1.26; 95% CI 0.70–2.28, $P = 0.45$). There were no differences for nullipara (1.9/1000 both groups; RR 0.99; 95% CI 0.45–2.21, $P = 0.99$) or parous clients (0.8 vs. 0.4/1000; RR 1.80; 95% CI 0.6–5.37, $P = 0.29$). Neonatal death in the first 7 days was not different (0.4/1000 vs. 0.6/1000; RR 0.71; 95% CI 0.23–2.25, $P = 0.57$). Likewise, there were no differences in Apgar scores below 7 at 5 minutes (1.5% vs. 1.4.%; RR 1.09; 95% CI 0.76–1.58, $P = 0.64$), neonatal intensive care unit admission (1.5% vs. 1.7%; RR 0.89; 95% CI 0.68–1.16, $P = 0.37$), or severe adverse neonatal outcomes. These data sets are, like most, underpowered to report the occurrence of rare events such as maternal mortality.

Most studies that include countries where midwifery is regulated or integrated into the health care system, including Canada, describe comparable neonatal outcomes.[12,13,15,18–20,26–29,32–35] Perinatal morbidity and mortality were the primary outcomes analyzed in 743 070 low-risk intended homebirths and intended hospital births with midwives in the Netherlands.[15] There was no difference in perinatal mortality in the first 28 days between intended homebirth or intended hospital birth for either nullipara (1.02/1000 for planned homebirths vs. 1.09/1000 for planned hospital births; odds ratio 0.99; 95% 95% CI 0.79–1.24) or parous women (0.59/1000 intended homebirths vs. 0.58/1000 for intended hospital births; adjusted odds ratio 0.99; 95% CI 0.87–1.55). Similarly, there were no differences between groups for neonatal intensive care unit admissions up to 28 days and low Apgar scores less than 7. The results were adjusted for gestational age, socioeconomic position, and ethnicity. These neonatal outcomes are consistent with the Canadian meta-analysis findings. Several studies from countries that do not meet Canadian standards for homebirth and lack the necessary criteria previously outlined have reported an increase in neonatal morbidity and mortality in out-of-hospital births.[17,22,36–39] These studies underscore the importance of a systems-based approach highlighted in Canada that supports homebirth safety.[40]

Thus, the data indicate that individuals at low risk for poor perinatal outcomes who plan homebirth with a regulated provider in an integrated health care system may have improved obstetric outcomes without increased neonatal morbidity or mortality.[15,18–20,28,29,31] These findings may be associated with provider skill level, interprofessional collaboration and communication, a proactive system-based approach that supports complete home and hospital integration, timely and coordinated referral processes, protection from financial disincentives, the unique characteristics of those who plan homebirth, and full access to obstetric services should transfer from home to hospital be required.[40]

The SOGC reaffirms and emphasizes the importance of choice for individuals and their families in the birthing process. In Canada, homebirth with a registered midwife or an appropriately trained physician is a reasonable choice for those who are evaluated to be at lower risk of obstetric or neonatal complications. All pregnant women should receive information about the risks and benefits of their chosen place for giving birth and should understand any identified limitation at their planned birth setting. Risk assessments should be ongoing throughout pregnancy and birth, and care providers must ensure the individual is advised of any change in their risk status to support their ability to make an informed choice for most suitable birth site.

Communication among and between the hospital and community care providers and policies and procedures providing for timely and appropriate emergency transport are critical components of an integrated system and should

remain a priority to support best practice outcomes. Where individuals make choices that are in conflict with recommendations, every effort should be made to maintain a therapeutic relationship and a respectful harm reduction approach from the team and include communication among all team members. SOGC Consensus Statement about multidisciplinary teams recognized the importance of collaborative practice and concluded that well-planned multidisciplinary care "will produce optimal care for our patients and rewarding and successful practices for all members of the care team."[41] The SOGC endorses evidence-based practice and encourages ongoing research into the safety of all birth settings. Prospective data collection should capture all births and include planned and actual place of birth.

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COUNCIL MEETING – MARCH 13, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Quality Improvement Committee Future

BACKGROUND:

The QI Committee is new, formed for the implementation of the QI program in 2019, and has replaced the Physician Practice Enhancement Committee. Previously, the QI Working Group met to provide advice on the formation of the new QI Program. Many of the same individuals were on both the previous Physician Practice Enhancement Committee and QI.

The purpose of the QI Committee is to facilitate the operation and oversee the administration of the QI Program which assesses a member in one or more of the following:

- Professional knowledge, behaviours, and skills
- Communication skills
- Practice management skills and
- Professional ethics.

Other than the initial meetings explaining the policies and procedures, and establishing new policies, there has been very little activity for the QI Committee to review the competence of medicine practiced by its members. Out of 140 completed reviews, 24 received an audit from which 5 were sent to the QI Committee for further consideration and review. This is very good news since in the initial review almost every physician was meeting the appropriate standard for the practice of medicine. The December meeting of QI was cancelled due to no files to review and there were only two re-audits to review at the February meeting.

The Central Standards Committee and Standards Department are actively rethinking their roles and mandates due to the changes in Chairs, Assistant Registrar, the transfer of accredited facilities to the Program Review Committee, the RHPA, and the creation of more Provincial Standards Committees under Bill 10, *The Regional Health Authorities Amendment Act (Health System Governance and Accountability).* Here are some considerations:

The Chairs of QI and Central Standards met with CPSM staff, Registrar, Assistant Registrar, and Medical Consultant to discuss the future of the QI Committee. The QI Committee then discussed this, as did the Central Standards Committee subsequently, and the Executive Committee. These are some considerations to take into account in making the decision on whether:

- Wind down and combine the QI Committee into Central Standards recognizing the similarity and overlap of their mandates and efficiencies to be created by having one

- Provide for a transition period as the QI Committee has just launched its first new cohort of specialists into QI and there might be some policy development required of the QI Committee over this year.
- The role and input of the public representative on QI is highly regarded for reasons of transparency, public input, and accountability – and it also prevents the "doctor group think" dominating the committee. The Group also recommends that public representatives (more than one) be included on the Central Standards Committee as evidence indicates it is easier to question or dissent from a group if there is more than one person.
- Anytime there are concerns with the practice of a member, there are multiple touch points as the concerns are elevated from QI Staff to QI Committee to Central Standards Committee to Registrar. These multi-touch points create what is called "regulatory lag" and increases the time lapse to deal with the matter and also requires greater resources to address the matter. Not only is this inefficient, but is the public interest and patient safety served by the regulatory lag?
- The accredited facilities reviews and approvals were previously undertaken by the Central Standards Committee, but this responsibility was transferred to the Program Review Committee under the RHPA.

Some members of the QI Committee were not in favour of collapsing the committee and expressed concerns including:

- Lack of adequate notice and inability to participate in the discussion by the QI Committee members.
- The familiarity with the QI process by individuals who participated in establishing the QI process will be lost at the Central Standards Committee.
- The QI Committee is still working out the processes and establishing policies as new cohorts enter and pass through the program.
- QI may not be a priority of the Central Standards Committee given the many diverse elements already on its agenda.

At its February meeting, the Central Standards Committee passed a motion to recommend to Council that the responsibilities and functions of the Quality Improvement Committee be absorbed into the Central Standards Committee following the June Council meeting.

At the same meeting, the Central Standards Committee also passed a motion to recommend to Council that public representatives be included in its membership composition.

The motions before Council have been divided into two. For clarity, if passed, this first motion before Council, if passed, will do two things effective June 19, 2020:

1 – absorb the responsibilities and functions of the QI Committee into the Central Standards Committee;
2 – end the Quality Improvement Committee; and

The second motion, if passed will require at least one third of the voting members of the Central Standards Committee be public representatives, similar in proportion to other CPSM Committees.

PUBLIC INTEREST RATIONALE

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

CPSM will still carry out the public interest to facilitate the operation and oversee QI assessing the members - whether QI resides in its own committee or as part of the Central Standards Committee.

MOTION:

A - NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The following amendments to the Central Standards Bylaw be approved, effective June 19, 2020:

- Delete the following from the list of Central Standards Subcommittees:
  2.c The College's Quality Improvement Subcommittee

The following amendments to the Governance Policy be approved, effective June 19, 2020:

- Delete s. 4.15.5 the Terms of Reference for the Quality Improvement Standards Subcommittee.

- Add the following to section 4.14 of the Central Standards Committee Terms of Reference in the Governance Policy.

  Authority
  4.14.1.a.i To provide an approved process to assess one or more of the member's professional knowledge, behaviours, skills (including, communication skills, and practice management skills), and professional ethics.

4.14.1.a.ii To facilitate the operation and oversee the administration of the College of Physicians and Surgeons of Manitoba Quality Improvement Program to assess a member in one or more of the following:

4.14.1.a.ii.1 professional knowledge, behaviours and skills;
4.14.1.a.ii.2 communication skills;
4.14.1.a.ii.3 practice management skills; and
4.14.1.a.ii.4 professional ethics.

4.14.3.a.vii Where a review by the QI Committee identifies a physician for whom further assessment and/or education is required, the subcommittee may provide advice to the physician regarding practice enhancement and quality improvement.

4.14.3.a.viii To assist with compliance with the QI Program where reasonable and to enforce compliance where necessary except that if the QI Committee is of the opinion a matter should be referred to the Registrar pursuant to s. 10.10(1) of the CPSM General Regulation.

4.14.3.a.ix The subcommittee has the authority to grant exemptions and deferrals as permitted by the CPSM General Regulation.

B - **NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:**

The following amendment to the Governance Policy be approved, effective June 19, 2020.

- Add the following to the Central Standards Committee Terms of Reference Composition:

  4.14.2.a.vii at least one third of voting members be public representatives.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 13, 2020

ITEM FOR INFORMATION

SUBJECT:

Strategic Organizational Priorities Update

BACKGROUND:

At the upcoming June meeting, Council will be asked to review the current Strategic Organizational Priorities, and add further priorities, or delete current priorities. A Progress Tracking Document is attached.

Some of the Priorities are "on hold" until FMRAC provides a framework or national level agreement and direction. Others will be completed over the 2020 calendar year. Another major priority is the multi-year review of the numerous Standards of Practice and Practice Directions.

It is time to begin considering new Strategic Organizational Priorities. At this stage, three possibilities have been identified:

1. **Continuity of Care** – Building upon the CPSO's four new policies, lessons learned from Statement 190, and changes in the health care system to enhance access to extended and after hours care, Council has already tentatively discussed this as a possible priority.

2. **Provincial Standards Committees** – Bill 10, the *Regional Health Authorities Amendment Act (Health System Governance and Accountability)* provides Shared Health and CPSM to establish CPSM Standards Committees. In discussions with Shared Health leadership the intent is to organize provincial standards committees partially along specialties. At the same time, with the appointment of a new Assistant Registrar and a new Chair of the Central Standards Committee this is an opportune time to refresh the current area and hospital standards committees, along with other standards committees with a view to developing more impactful outcomes.

3. **Complaints and Investigations Streamlining** – At the last meeting of Council there was discussion about CPSO's successful initiatives in streamlining their processing of disciplinary complaints and investigations that have yielded very significant benefits in timeliness, satisfaction, and cost for patients and physicians. At the same time CPSO introduced mediation which is permitted under the RHPA. Given the current length of complaints and investigations and costs, this is something CPSM could include as a Strategic Organizational Priority.

At this meeting of Council other possible priorities will be canvassed from Councillors. No decisions will be made at this meeting, but discussions will be held for consideration of new priorities at the June Council meeting.

PUBLIC INTEREST RATIONALE

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

All three possible priorities are firmly within the public interest by improving patient safety by fulfilling CPSM's mandate and enhancing the quality of care by physicians.

Reports from the three ongoing Working Groups follow. The fourth Working Group has already submitted to Council its recommended Standard of Practice for Prescribing Benzodiazepines.

CPSM
ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Benzodizaepine Prescribing Standard of Practice		Sep-19	Sep-20	Started Oct 2019	Mar-20	April May 2020	Jun-20	Sep-20	On Track	Five Meetings Held
Cannabis Authorization Standard of Practice		Sep-19	Sep-20	Started Nov 2019	Mar-20	April May 2020	Jun-20	Sep-20	Delayed	Five Meetings Held, Draft Expected for June Council
Streamlined Registration - Fast Track Application	FMRAC-Started								Not Started	
Streamlined Registration - Portable Licence	FMRAC-Started								Not Started	
Artificial Intelligence	FMRAC-Started								Not Started	
Telemedicine	FMRAC-Started								Not Started	
Extended/ After Hours Coverage		2015	Jun-19	Finished 2019	Mar-19	N/A	N/A	N/A	Achieved	Initiative paused for Healthcare system transformation
Maintaining Boundaries - Sexual Involvement with a Patient		Sep-19		Started Sept 2019	Jun-20	TBD	TBD	TBD	On Track	Five Meetings Held
Governance Review		Jun-19	Dec-19	Started Sept 2019	TBD	N/A		TBD	Achieved	
Standards of Practice Ongoing Review - 4 Year Cycle		Jan-20	Dec-24						On Track	Starting
Accredited Facilities Criteria		Sep-19		Started Oct 2019	Mar-20	April May 2020	Jun-20	Sep-20	Delayed	Five Meetings Held, Draft Expected for June Council

Last revised: February 28, 2020

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 13, 2020

ITEM FOR INFORMATION

SUBJECT:

Standard of Practice for Authorizing Medical Cannabis

The Working Group has met five times and has a draft Standard that is not quite ready for review by Council. The Standard of Practice articulates the standard of practice and ethical requirements for all members using their clinical skill, knowledge, and judgment in authorizing cannabis for medical purposes.

The Working Group is building upon the current Standard of Practice. The challenge has been to balance between:

- the need to authorize cannabis when clinically required,
- a patient group with great but often misplaced expectations for its healing powers,
- the harms and risks of cannabis,
- its availability recreationally,
- the complexity of cannabis itself,
- limited good quality evidence to support cannabis use for most medical conditions, and
- lack of knowledge accompanied by prejudice to cannabis for medical purposes from some physicians.

Cannabis has many aspects that do not fit well with the traditional medical model for drug prescribing. Uniform dosing and titration schedules have not been established. The cannabis product itself can vary significantly by producer making its effect unpredictable and unreliable. The user is likely exposed to a product that may have varying ratios and amounts of THC and CBD cannabis components, even within the same strain and same producer. Thus, the cannabis effect may be highly and unexpectedly variable. Not only does this contribute to the difficulty in patients receiving precise doses but dispensers are not obligated to provide the cannabis product strength (e.g. CBD-prominent, CBD-THC-balanced, THC-prominent) recommended or authorized by the member.

The Working Group does not intend to produce clinical guidelines for authorizing medical cannabis. Rather it will rely upon other major works. There is valuable information on authorizing medical cannabis, clinical pharmacology, dosing, potential therapeutic uses, warnings, adverse effects, and overdose toxicity in Health Canada's 2018 *Information for Health Care Professionals – Cannabis (marihuana, marijuana) and the Cannabinoids* and in the College of Family Physicians of Canada's 2018 *Simplified Guideline for Prescribing Medical Cannabinoids in Primary Care*.

The Standard will also cover the medical profession issuing approvals that allows patients to grow their own cannabis plants for medical purposes.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 13, 2020

ITEM FOR INFORMATION

SUBJECT:

Boundaries Violations Working Group Progress Report

The Boundaries Violations Working Group has met monthly beginning in October 2019 - (5 meetings to date and 2 more scheduled for March and April). The Working Group has addressed all of the issues on our work plan and reached consensus. In March the Working Group will review a draft report to Council and in April they will be asked to approve a final report with recommendations.

The Working Group consists of seven physicians from diverse backgrounds, 2 public representatives and one representative of another regulated health profession. The College President is also an ex officio member of the committee and four College staff support the working group. One member of the working group has been unable to attend any of the meetings of the Working Group to date but otherwise attendance has been remarkably good and Working Group members have actively engaged in the process.

The Working Group reviewed a lot of written material on Boundary Violation policy from a number of other Canadian jurisdictions and from other countries and other regulated professions as well. They also received reports from College staff on current practices and policies and on the Manitoba experience to date with Boundary Violations.

The Working group spent a fair bit of time on penalties and in particular whether there should be minimum penalties proscribed for certain boundary violations. There was also an analysis of presumptive penalties and whether there was any merit in adopting those. The consensus of the Working Group was that there should not be minimum penalties or presumptive penalties. There were many reasons for this which will be set out in the Working Group report, but the bottom line was an agreement that minimum penalties or presumptive penalties would impede, not enhance, public protection.

The Working Group will be recommending adoption of a trauma-based approach to boundary violations that offers support to patients throughout the process.

The Working Group will be recommending some changes to the Standards of Practice on Boundary Violations to improve clarity about what is and is not acceptable conduct and practice.

The Working Group will be recommending changes to the complaint and hearing processes consistent with a trauma-based approach while preserving fairness in the process for all parties.

The Working Group will be recommending an enhanced communication strategy to better and more effectively explain to physicians and patients some of the expectations, options and processes connected to boundary issues.

Finally, the Working Group will be recommending training for college staff, Complaints, Investigation and Hearing Committee members on boundary issues.

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 13, 2020

ITEM FOR INFORMATION

SUBJECT:

Non-Hospital Surgical Facilities Update

The purpose of the Working Group is to review Part B of the Accredited Facilities Bylaw and recommend the criteria determining which non-hospital medical or surgical facilities should be accredited to ensure patient safety. The Working Group has met on five occasions and has prepared the beginnings of a Draft Report and Recommendations. The Working Group is utilizing this framework to make its recommendations:

I - Risk to the patient (patient safety) is the basis upon which CPSM should accredit facilities.

II –These are the risks to patients in facilities that are diagnosing and performing treatment:

a) Infection
b) Anaesthesia < ---- > sedation continuum
c) Invasiveness
d) Complexity of procedures
e) Potential for complications
f) Safe equipment and operation
g) Qualifications of staff (RN, technicians)
h) Qualifications of physicians (including requirement for anesthesiologist)
i) Sole practitioner facility
j) Appropriate patient selection
k) other

III – The current criteria of procedural sedation do not fully address the above risks to patients in facilities.

IV – Other criteria should be used to determine which non-hospital surgical facilities require accreditation.

V – Certain procedures require accreditation to address the above risks to patients:

a) Review by area of specialty
b) Compare to other jurisdictions

VI – Are there any procedures that fall into the above risks and the new criteria, but could be excluded based on a solid rationale?

VII – The role of Medical Director is critical to successful CPSM accreditation and oversight.

VIII – A jurisdictional scan of other provinces was reviewed.

Based upon its analysis of risks and its review of other jurisdictions, the Working Group seems to be landing upon using the following criteria for assessing risk of potential harm to a patient and therefore requiring accreditation of facilities:

1) Level of Anesthesia and/or Sedation
2) Need for Medical Device Reprocessing (infection risk)
3) Complexity of Procedure and Risk of Complications

The Working Group is also developing a set of procedures requiring CPSM accreditation prior to being performed outside of a hospital. A report and recommendations are partially drafted and will be finalized for the June Council meeting.

COUNCIL MEETING – DECEMBER 13, 2019

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Privacy Policy

DISCUSSION:

CPSM is committed to protecting the privacy and confidentiality of information it receives, creates, uses, maintains and discloses while fulfilling its regulatory functions. This may include information about members of Council or its committees, CPSM members, members of the public, as well as employees, contractors and appointees of the CPSM. All people either employed or involved in the activities of the CPSM who obtain confidential information, must, by law, keep that information confidential. A new practice is to sign annual declarations of confidentiality which provides a good reminder of this duty of confidentiality.

In furtherance of this commitment, the Registrar has proposed the development of a Privacy Policy. Adoption of this policy would serve to fulfill CPSM's commitment to privacy and confidentiality. CPSM does not currently have a Privacy Policy yet should as a best practice. It is of note that all other Colleges in the country have established privacy policies, and these were reviewed in drafting the Privacy Policy under consideration.

The Privacy Policy is largely consistent with the requirements set out at subsection 140(2) of the RHPA, though adds increased guidance in how confidentiality is to be maintained.

Of particular significance, this privacy policy would create normative standards for approaching confidentiality issues and will serve as reassurance to third parties the information they provide to CPSM will be properly maintained.

The attached Draft Privacy Policy requires approval of Council.

PUBLIC INTEREST RATIONALE:

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

CPSM has in its possession very confidential information including patient records, in addition to personal information regarding its members. It is incumbent upon CPSM to protect this information both within CPSM Departments and the CPSM itself. Of particular significance, this privacy policy would create normative standards for approaching confidentiality issues and will serve as reassurance to third parties the information they provide to CPSM will be properly maintained.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

The Privacy Policy be approved.

POLICY

Privacy Policy

Initial Approval: March 13, 2020 **Effective Date: March 13, 2020**

1. PURPOSE

The College of Physicians and Surgeons of Manitoba is committed to protecting the privacy and confidentiality of information that it receives, creates, uses, maintains and discloses while fulfilling its regulatory functions. This may include information about members of Council or its committees, members of the College, members of the public, as well as employees, contractors and appointees of the College. The College fulfills this commitment to privacy and confidentiality by voluntarily adopting the practices set out in this Privacy Policy and by complying with its statutory obligations under the RHPA, particularly subsection 140(2).

2. SCOPE

This Privacy Policy applies to every person employed, engaged or appointed by the College for the purpose of administering or enforcing *The Regulated Health Professions Act* (the "RHPA"), and every member of Council, a committee of Council or board established under the RHPA. For simplicity, all these actors will be referred to collectively as the "College" within this Privacy Policy.

This Privacy Policy establishes confidentiality requirements consistent with or in addition to the requirements of the RHPA and its regulations, Council bylaws and Practice Directions, and other College and Council policies

3. PRINCIPLES OF PRIVACY AND CONFIDENTIALITY THAT MUST BE FOLLOWED

3.1. Collection and use of information

The College collects, uses and maintains information in accordance with the RHPA and always in furtherance of its mandate to serve and protect the public interest and administer the RHPA.

3.2. Identifying purposes

Communication of information requires careful consideration of the purpose for the request and/or disclosure and whether that purpose is consistent with the proper administration of the RHPA, regulations, College Bylaws, Standards of Practice of Medicine, Practice Directions, or policy, including this Privacy Policy:

- The College will make a reasonable effort to identify the purpose(s) for which information is collected to the individual from whom the personal information is collected, either at the time of collection or after collection but before use, except where inappropriate.

- Where applicable, the College will state the identified purposes in such a manner that an individual can reasonably understand how the information will be used or disclosed.

- Personal information and personal health information should generally not be used for purposes other than those stated when the information was obtained. Notwithstanding, use of information for unanticipated purposes is permitted when the information becomes relevant to another aspect of the College's mandate.

- When information that has been collected is to be used for a purpose not previously identified, the new purpose should usually be identified prior to use where practical and appropriate. Unless the new purpose is required by law or patient safety, the consent of the individual should be obtained before the information is used for the new purpose.

3.3. Documenting requests and disclosure

Requests for information and disclosure of information by the College should be documented, including the reasons for the request or disclosure, related conversations and the outcome. Where this information is self-evident from the request or disclosure itself, which may be in the form of a letter or email, separate documentation would not be necessary.

3.4. Consent

The College respects and values an individual's right to provide or withhold consent in relation to their information. However, there are many instances in which obtaining consent will impede the College's ability to fulfill its regulatory functions. The College will collect, use, disclose or retain information without consent only when it is permitted or required by law to do so. In all other situations, the College will obtain consent.

3.5. Limiting collection

Personal information and personal health information regarding patients must be collected as part of the College's regulatory function. In most circumstances, this information is obtained by the College as part of either the complaints or the standards process. The focus of these processes is the conduct, competence or capacity of members and the protection of the public. The College only collects information regarding patients to satisfy its regulatory mandate. In general, no more information than is necessary is sought or disclosed by the College.

3.6. Limiting use, disclosure or retention

Information is only disclosed externally from the College in accordance with the provisions of the RHPA or as otherwise required by law or patient safety, including the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act*.

The RHPA and Regulations designate certain information regarding members that is publicly available and create the requirement for physician profiles.

The College may be required by law enforcement, government institutions, or judicial or other regulatory authorities to provide certain information that is in its control or possession without consent or notice to any or all persons having a privacy interest in the information.

The College's responsibilities regarding personal information and personal health information apply where information is transferred to a third-party for a purpose consistent with the administration of the RHPA or other legislation. Where possible, the College will use contractual or other means to provide a comparable level of protection while the information is in the possession of a third-party.

The College has a record retention policy in place and conducts regular audits to ensure that personal information that is no longer required to be kept is destroyed, erased or obtained by contacting the Registrar at the College.

3.7. Accuracy

Accurate information is vital to the Colleges' ability to fulfill its regulatory functions. In recognition of this fact, the College will take reasonable steps to ensure that the information it collects, uses, discloses and retains is accurate. This may include contacting individuals who have provided the College with information in order to verify accuracy. If there exist concerns with the reliability of information, the concerns should be documented and brought to the attention of the appropriate director or the Registrar.

3.8. Safeguards

The College recognizes that adequate safeguards are fundamental to maintaining the privacy and confidentiality of information. The College will take reasonable steps to ensure that the information it receives or creates is protected against theft, loss or other misuse. While the specific safeguards implemented will be tailored in accordance with the degree of sensitivity of the information, the College will ensure that:

- Information is stored in a secure manner, which may include keeping information in secure or restricted access storage rooms, maintaining information in password protected databases, and/or requiring that information is signed-out when it is removed from the College;
- Information which is no longer needed will be destroyed in a reliable manner, including by shredding of physical records through a professional and confidential service;
- Access to the College premises will be restricted to College staff and authorized persons; and

- Reasonable steps are taken to ensure that staff, members of Council, members of Committees and other individuals who conduct work for the College are made aware of their obligations to keep information confidential and understand the importance of upholding this obligation.

3.9. Accountability

The Registrar shall administer this Privacy Policy pursuant to subsection 2.2 of the Registrars, Duties Authority and Evaluation – Council Policy. In fulfillment of this duty, the Registrar will:

a. with respect to all those to whom this policy applies:

   i. ensure that they received adequate training regarding College confidentiality requirements, including this Privacy Policy, and

   ii. ensure that all those to whom this Privacy Policy applies execute a declaration of confidentiality; and

b. publish the College's policies regarding privacy, including this Privacy Policy, on the College's website.

Any concerns or questions arising regarding compliance with this Privacy Policy should be brought to the attention of the Registrar for review. If the concern relates to the Registrar, it must be brought to the President of the College for review. When a concern is received, the Registrar, or President as the case may be, shall:

- acknowledge receipt of the concern;
- investigate the concern;
- provide a written response regarding the concern to individuals who are directly impacted providing only information that is necessary and disclosable under subsection 140(2) of the RHPA; and
- take appropriate measures.

4. APPLICATION OF OTHER PRIVACY LEGISLATION

The College is not engaged in "commercial activity" as defined in *The Personal Information Protection and Electronic Documents Act* ("PIPEDA") and as such its collection, use and disclosure of personal information is not covered by PIPEDA, which is a federal statute that governs organizations operating in the private sector in Manitoba. The College has been designated an "investigative body" under PIPEDA in order to permit organizations that are (or will be) governed by PIPEDA to be able to provide personal information about members to the College on a voluntary basis.

Manitoba's public sector privacy legislation, the *Freedom of Information and Protection of Privacy Act* (FIPPA), does not include professional regulatory bodies under its jurisdiction. Similarly, the *Personal Health Information Act* (PHIA), which specifically governs privacy in the context of health service providers, does not include professional regulatory bodies under its jurisdiction. The College is not a "trustee" as defined in PHIA and as such is excluded from the provisions of PHIA relating to trustees of personal health information. Section 22 of PHIA permits the disclosure of personal health information by trustees to the College.

COUNCIL MEETING – MARCH 13, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Recommendation to Minister for Roster of Public Representatives

BACKGROUND:

For any new appointees to the Complaints/Investigation/Inquiry Committee, from the RHPA forward, only Ministerial appointees to the s. 89 roster can serve on any of the discipline committees. There is a section 89 roster of newly appointed public representatives for these three disciplinary committees. The Minister made the following appointments to this roster:

- Ms. Eileen Gelowitz until Dec 3, 2021
- Mr. Raymond Strike until Dec 3, 2021
- Ms. Leanne Penny until Dec 3, 2021
- Mr. David Bjornson until Dec 3, 2022
- Mr. Alan Scramstad until Dec 3, 2022
- Ms. Elizabeth Tutiah until Dec 3, 2022
- Ms. Lynette Magnus until Dec 3, 2021

Note that none are four year appointments.

Executive Committee, acting between the annual appointments to committees by Council, made the following appointments:

Complaints:	Leanne Penny and Raymond Strike
Investigations:	Lynette Magnus and Elizabeth Tutiah
Inquiry:	David Bjornson and Alan Scramstad

It should be noted the current public representatives on the Inquiry Committee can not simply be carried forward under the RHPA. It is suggested that the Minister be approached once again with a request to appoint the current Inquiry Committee members to the s. 89 roster from which CPSM can choose members for the three committees. They are as follows:

- Ms Sandra Benavidez
- Mr. Ryan Gaudet
- Ms Sandra Martin
- Ms Heather Reichert
- Ms Diana Yelland

Each has indicated their interest in continuing to be a member of the Inquiry Committee.

PUBLIC INTEREST RATIONALE:

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

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON MARCH 13, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE THAT:

To nominate to the Minister the following individuals to be public representatives on the roster of public representatives in accordance with section 89 of the RHPA:

- Ms Sandra Benavidez
- Mr. Ryan Gaudet
- Ms Sandra Martin
- Ms Heather Reichert
- Ms Diana Yelland

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 13, 2020

ITEM FOR INFORMATION

SUBJECT:

CEO/Registrar's Report

1. Staffing Matters

Dr. Ainslie Mihalchuk has started as Assistant Registrar, replacing Dr. Terry Babick. A new Application Review Analyst has joined the CPSM in the Qualifications and Registration Department.

CPSM is seeking a new part-time Patient Advisor/Liaison in the Complaints/Investigation Department. Their primary role is to provide ongoing direction and support to complainants as they navigate/move through CPSM's complaints/investigations process. This person will provide emotional support and ongoing contact with complainants alleging sexual boundary violations. Elevated support will also be provided to those who have exceptional circumstances, including where the matter involves the death of a family member or complainants with challenges that may affect their ability to participate in the process, such as mental illness or low level of literacy. We regard this role as crucial to fulfilling the CPSM mandate to serve and protect the public.

2. Changes in Council Membership Under the RHPA

There will be various changes to Council membership as required under the RHPA. The main changes are to have defined limits to Councillor terms and a transition to a shrinking Council. The following is an explanation of these changes.

The RHPA provides:

> 14(2) A person may be a council member for more than one term. But a person must not be a member for more than twelve consecutive years.

At the end of their respective terms, Dr. Domke (1996-2020) and Dr. Lindsay (2006-2022) will no longer be eligible for Council as they will have reached twelve consecutive years. Drs. Vorster, Manishen, Postl, and Ripstein (all elected in 2010) will reach 12 consecutive years in 2022.

Under the RHPA the size of Council decreases from 22 to 18, while public representatives increase from 4 to 6. Therefore, the balance of public representatives to physicians change. Ultimately there are 5 positions in Winnipeg. In 2020 Brandon and Westman combine into one seat – West. Eastman will have a 2 year bridge period from 2020 - 2022. In 2022 Eastman and Central combine into one seat – East. Also, in 2022 Interlake, Parkland, and North combine into one seat – North. There are also two positions for President and Past President.

The University seat combines into one in June 2020. However, Dr. Ripstein will remain on Council regardless, as there is an additional seat for the President.

In 2020 there will be an election for:

- three Winnipeg Council positions currently held by four: Drs. Domke, Kvern, Silha, and Suss (Dr. Domke is not eligible to run again)
- one seat in the new West region for a four-year term (currently held by Dr. Duncan, whose 12 year limit expires in 2023 and Dr. Vorster whose 12 year limit expires in 2022, so neither will be able to complete the four year term if they decide to run and are elected)
- one seat in existing Eastman region for a two-year term (currently held by Dr. Shenouda)
- new associate position (currently held by Dr. MacDowell and requires an annual election)

See attached chart for all Councillors' terms.

3. Annual General Meeting of the Members

The Annual General Meeting of the Members will immediately precede the June 19, 2020 Council meeting. Both meetings will take place in the CPSM boardroom.
The agenda will include:

- Approval of financial statements
- Appointment of auditors
- Approval of bylaw amendments
- Report on the Major Activities of the CPSM

The Report on the Major Activities of the CPSM will be fairly lengthy as this will constitute a written and oral report (PowerPoint) on the Strategic Organizational Priorities and Reports from each Committee Chair or senior staff member assigned to that Committee.

4. Electronic Document and Records Management Project – Paperless

CPSM does not have an Electronic Document and Records Management System and instead relies upon manual and paper-driven processes to store and archive its documents and records. CPSM can realize increased efficiencies, data management, internal controls, and reporting improvements from its current state by implementing an integrated and modern solution. This project represents a significant transformation and investment in time, energy, and money. The primary focus is records retention and management across the organization with document management as a secondary priority.

An RFP has been issued and CPSM is currently reviewing the proposals submitted and asking some companies to provide a detailed submission to select a system integrator who will partner with CPSM and supply an Electronic Document and Records Management System that will meet CPSM's current and future needs.

Some other Canadian colleges have very recently embarked upon an Electronic Document and Records Management (Paperless) System and CPSM has been able to utilize much of their knowledge and experiences.

5. Expedited Licensure

This refers to the Strategic Organizational Priority of Streamlined Registration – Fast Track License. Six provinces are working together to create the framework for an expedited licence. The provinces are in the midst of agreeing to the specific detailed requirements, the application itself, and the wording of the questions to be asked of each applicant. Government has been advised that Manitoba will require amendments to its regulations, the only participating province requiring such an amendment.

6. Prescriber Profile

Prescriber Profiles will be provided to all Manitoba physicians on an annual basis. Currently our focus is on opioid prescribing practices.

The Prescriber Profiles are being generated in collaboration with Manitoba Health, Seniors, and Active Living using actual opioid prescribing data from the DPIN network. Each Prescriber Profile will capture individual physician's opioid prescribing practices and compare it to a peer group of physicians with a similar practice**.** The Prescriber Profiles will also provide a snapshot of overall opioid prescribing trends in Manitoba.

Individualized patient specific feedback on prescribing practices has been shown to be effective in changing practice. This is an educational initiative that will ask physicians to reflect on their opioid prescribing practices as compared to other physicians with a similar practice. In future, reviewing the individualized opioid prescriber profile will also form part of each physician's peer review process.

Emails were sent recently to every practicing physician in the province with a list of the practice categories compiled utilizing data provided by Manitoba physicians thus far. Physicians were asked to take a moment, review these categories and if one of these

categories appropriately describe their practice, check it off. If their practice is not accurately represented by any of the options on the list, then they could use the comment section to describe their practice including the approximate percentage of time spent on each component of clinical practice.

7. FMRAC – Prescribing Opioids Guidelines

The Federation of Medical Regulatory Authorities of Canada approved Prescribing Opioids Guidelines which provides recommendations and proposed minimum regulatory standards to the Colleges to guide physicians who prescribe opioids to patients with pain and/or opioid use disorder. It acts as a complement to CPSM's Standards of Practice for Prescribing Opioids. It is attached.

8. Media

There has been no media coverage of CPSM of note in the past three months.

9. MAID Consultation

MAID legislation was implemented in 2016. Given the complexity of some of the issues raised and uncertainty around how such a regime could be implemented, the Government of Canada committed to further study on three complex types of requests (i.e., requests by mature minors, advance requests, and requests where a mental illness is the sole underlying condition).

As Registrar I attended an invitation only consultation with the federal Government on Medical Assistance in Dying. This was part of the recent wider consultation by the federal Government on three key areas: changes to eligibility criteria; modified and/or additional safeguards; and, final consent and advanced requests.

You might be interested to know that since the implementation of the legislation, MAID represents slightly over 1% of all deaths in Canada. In Canada, the average age of persons receiving MAID is approximately 72, with men and women equally represented. Since the implementation of the regime, cancer has consistently been identified as the most frequent underlying medical condition for MAID cases, followed by neurological conditions and cardiovascular and respiratory conditions. The profile of persons receiving MAID is consistent with what one would expect in a regime where eligibility is limited to persons nearing the end of life and does not raise concerns about abuse of the system.

In September the Superior Court of Québec found that the "reasonable foreseeability of natural death" requirement in the federal legislation and the "end-of-life" requirement contained in Quebec's legislation are unconstitutional. The remaining criteria are unchanged (i.e., a person must have a serious and incurable illness, disease or disability, be in an advanced state of irreversible decline, and experience unbearable physical or mental suffering that cannot be alleviated under conditions considered acceptable by the individual).

These criteria continue to be valid until the decision comes into effect on March 11, 2020. This ruling only applies in the province of Québec, which means that the "reasonable foreseeability of death" criterion will remain in effect in other provinces and territories until such time as federal law is amended.

The federal Government announced its intention to introduce legislation to amend MAID. CPSM will ensue its MAID Standard of Practice conforms if and when the legislation is passed.

10. Lawsuit by the Manitoba Chiropractors Association

The Manitoba Chiropractors Association filed a lawsuit against CPSM more than one year ago. I attended an examination for discovery in the summer during which CPSM legal counsel objected to many questions asked of me by MCA's legal counsel and so I did not respond to the questions. The MCA sought to have the court compel me to answer these questions. The court decided that all but one of the questions were not relevant to the litigation and therefore I was correct in not responding.

11. Pandemic Planning

CPSM is participating with the Province, Shared Health, and RHAs on possible pandemic planning for the corona virus. The CPSM website has a link to the provincial website on coronavirus which is updated daily.

12. FMRAC Snapshot

See attached.

Councillor Term Listing

Council Members	Yrs	# of Terms	1996 - 2000	2000 - 2004	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Start Date	End Date	Comments
Public Representatives																													
Agger, Leslie	1	1																									8-Jul-19	19-Jun-23	CPSM Appointed
Albrecht, Dorothy	1	1																									23-Jul-18	19-Jun-20	CPSM Appointed
Magnus, Lynette	2	1																									16-Jun-18	15-Jun-22	CPSM Appointed
McPherson, Marvelle	3	1																									13-Apr-17	28-Feb-21	Government Appointed
Fineblit, Allan	3	1																									30-Mar-17	28-Feb-21	Government Appointed
Penny, Leanne	2	1																									17-Dec-19	16-Dec-21	Government Appointed
Councillors																													
Domke, Dr. Heather	24	6																			X						15-Jun-96	19-Jun-20	\
Kvern, Dr. Brent	2	1																									17-Oct-17	19-Jun-20	\ June 2020 - 4 positions become 3
Silha, Dr. Josef	3	1																									17-Jun-16	19-Jun-20	/
Suss, Dr. Roger	2	1																									14-Aug-18	19-Jun-20	/
Duncan, Dr. Stephen J.	9	3																					X				18-Nov-11	19-Jun-20	\ June 2020 - 2 positions transition to 1
Vorster, Dr. Alewyn	10	3																				X					28-Jul-10	19-Jun-20	/
Shenouda, Dr. Nader	4	2																									6-Jan-16	19-Jun-20	\ June 2020 Position elected for 2 yr period
Convery, Dr. Kevin	2	1																									15-Jun-18	15-Jun-22	/ June 2022 - 2 positions transition to 1
Blakley, Dr. Brian	2	1																									15-Jun-18	15-Jun-22	\
Manishen, Dr. Wayne	10	3																					X				15-Jun-10	15-Jun-22	\
Sigurdson, Dr. Eric (PP)	5	2																									15-Jun-14	15-Jun-22	\ June 2022 - 5 positions transition to 2
Kumbharathi, Dr. Ravi	2	1																									15-Jun-18	15-Jun-22	/
Smith, Dr. Heather	1	1																									15-Jun-18	15-Jun-22	/
Elliott, Dr. Jacobi (PE)	1	1																									15-Jun-18	15-Jun-22	\
Lindsay, Dr. Daniel	14	4																					X				15-Jun-06	15-Jun-22	\ June 2022 - 3 positions transition to 1
Stacey, Dr. Brett	1	1																									1-Nov-19	15-Jun-22	/
Associate Member																													
MacDowell, Dr. Matthew	1	1																									21-Jun-19	19-Jun-20	Yearly Elected
University Appointed (Yearly)																													
Postl, Dr. Brian	10	10																					X				15-Jun-10	19-Jun-20	\ June 2020 - 2 positions transition to 1
Ripstein, Dr. Ira (P)	10	10																						X			15-Jun-10	19-Jun-20	/ Past President completes term
as of February 19, 2020																													

Red and dark black lines indicate election years

X means member has completed 12 years of service and is not eligible to run for Council that year

Federation of Medical Regulatory Authorities of Canada

Fédération des ordres des médecins du Canada

Framework for FMRAC's Members on a Regulatory Approach to Physicians Who Prescribe Opioids

Purpose

The purpose of this Framework is to provide recommendations and propose minimum regulatory standards to FMRAC's members, i.e., the Medical Regulatory Authorities (MRAs) in Canada, to guide physicians who prescribe opioids to patients with pain and/or an opioid use disorder[1].

This Framework complements existing MRA policies and guidance to physicians and strives for pan-Canadian consistency in opioid prescribing. As FMRAC has no authority over its members, it is the discretion of the individual MRAs to adopt or adapt these recommendations as they deem appropriate and/or feasible**.**

Preamble

Prescription opioids can be effective for patients suffering from pain and/or an opioid use disorder. Physicians have a responsibility to manage their patients' pain and/or opioid use disorders, and this requires appropriate knowledge, skills and training. It also relies on open communication with patients, compassion and sound professional judgement, to ensure the effectiveness of the treatment plan, maintain the dignity of patients, as well as assure patient and public safety.

It is incumbent on MRAs to develop balanced approaches to support, guide and, where appropriate, identify and monitor physician opioid prescribing, to mitigate and safeguard against the risk of harm to patients.

Ethical, Professional and Legal Obligations

It is expected that all MRAs develop and implement policy that is informed by evidence and/or best practice and considers potential unintended consequences, including but not limited to stigmatizing patients and/or compromising either their health (e.g., rapid tapering or abruptly ceasing medications) or reasonable access to care. FMRAC believes that such policy must also articulate expectations that physicians comply with relevant legislation, including applicable human rights legislation, to ensure non-discrimination against any patient with pain and/or an opioid use disorder who requires opioids. It also expected that all MRAs have clear policies for physicians on accepting new patients and terminating existing patients to ensure their decisions are fair and non-discriminatory to those currently using opioids for pain and/or those with an opioid use disorder.

MRA policies must also emphasize the ethical and professional obligations of physicians, as well as current regulatory policies and guidance in their jurisdiction, on matters including but not limited to:

[1] *Please note: This Framework does not apply to chronic pain in the context of active cancer pain, palliative and end of life care*

- the patient-physician relationship;
- accepting new patients;
- informed consent;
- medical records;
- privacy and confidentiality;
- follow-up with patients;
- expectations of ongoing competence, including when prescribing opioids for acute pain, chronic pain, an opioid use disorder and/or opioid agonist therapy;
- expectations of professionalism when collaborating with patients, colleagues, pharmacists and others involved in the provision of health care; and
- educational and/or clinical training requirements and, if applicable, requirements for evidence of their completion.

Principles

FMRAC also recommends that MRA guidance documents, policies and related communications materials address physicians' ethical and professional responsibilities to:

- strive to balance the needs of their patients with the potential harms of opioid prescribing to patients and the public;
- provide care that is culturally sensitive, supports open communication with patients and informed decision-making when initiating, tapering, and/or discontinuing opioids; and
- establish mutual and clear expectations with patients while remaining compassionate.

It is further recommended that these materials are regularly reviewed and updated to ensure they do not inadvertently stigmatize patients.

Recommendations Regarding Professional Guidance by MRAs

FMRAC also recommends that the following be adopted by all MRAs in their policies and professional guidance to physicians when prescribing opioids for acute pain, chronic pain, non-active cancer pain, opioid use disorders and/or opioid agonist therapy.

Physicians must:

1. First perform and document a relevant and appropriate clinical assessment based on the patient's presentation to ensure that an opioid prescription is the most appropriate course of action and will meet the patient's needs.
2. Inform patients about the potential benefits and harms of opioids, including but not limited to physical dependence, tolerance, withdrawal, overdose and death. Physicians must also address how to safely secure and store opioids and dispose of those unused, as well as review the potential consequences of diversion.
3. Collaborate and communicate, both verbally and in writing, with their patient's health care team and other providers, as appropriate.
4. Access provincial prescription monitoring programs when and where available.
5. Make evidence-informed decisions and document justification when varying from evidence-based guidelines and best practice for the management of pain, and/or an opioid use disorder.

Recommendations to the Medical Regulatory Authorities (MRAs)

FMRAC also recommends that all MRAs, where appropriate and/or feasible,**:**

1. advocate for and support the development and maintenance of pan-Canadian guidelines relating to pain management, opioid prescribing and opioid use disorder, as well as the management of chronic pain in specific and high risk populations, and encourage their application by physicians;
2. ensure prescribing standards are being maintained by collaborating with their respective Office of the Chief Medical Examiner/Coroner and other stakeholders to facilitate a process for the annual identification and review, by the respective MRA in their jurisdiction, all deaths attributed to prescription medications, including opioids;
3. collaborate with stakeholders to facilitate the development of a process for regularly sharing with opioid prescribers the outcomes and lessons learned from the review of all opioid-related deaths and serious medical complications;
4. encourage physicians to report adverse drug reactions to Health Canada and medication incidents to the appropriate body;
5. work with FMRAC, governments and other stakeholders to promote: i) the development of prescription monitoring programs in every province and territory; ii) the standardization of data elements and their collection; iii) recommendations on common quality indicators; and iv) data that are available and easily accessible by medical regulatory authorities and other stakeholders, and shareable across jurisdictions;
6. identify and monitor quality indicators relating to appropriate opioid prescribing;
7. collaborate with patients, including those with lived experience, and contribute to the work of these and other stakeholders (including pharmacy, nursing and dental regulators) on issues and/or activities relating to clinical and regulatory guidelines, education and mentorship opportunities, medication safety and surveillance;
8. encourage stakeholders to support the development of plain language patient information and resources, particularly for vulnerable populations, about opioids in general, as well as how to safely secure and store them, and dispose of those unused;
9. collaborate with regional health authorities, correctional services and primary care providers in the community to advocate for consistent policies and systems that facilitate reasonable access to appropriate and safe opioid treatment for pain and/or management of opioid use disorder, as well as non-pharmacological pain management options;
10. work with stakeholders to advocate for: i) patient access to the full continuum of opioid agonist therapy and evidence-based harm reduction interventions, particularly in rural and remote or underserviced areas; ii) non-pharmacological pain management options to be more broadly accessible to and affordable by patients; and iii) the availability of culturally sensitive care;
11. provide on their websites, or facilitate easy access to, information about educational programs as well as mentorship opportunities relating to pain management and the and the management of opioid use disorders.

Snapshot – Winter 2020

Federation of Medical Regulatory Authorities of Canada

Fédération des ordres des médecins du Canada

Dr. Linda Inkpen
President

Ms. Fleur-Ange Lefebvre
Executive Director & CEO

Board of Directors

The Board met twice since the last issue of *Snapshot*: 4 December 2019 (by teleconference) and 6 February 2020 (in person in Toronto, ON).

- Current organizational priorities
  - Prescription opioids – the *Framework for FMRAC's Members on a Regulatory Approach to Physicians Who Prescribe Opioids* was **approved**
  - Physician competence – this file will resume with a focus on reviewing and possibly updating the 2016 *FMRAC Physician Practice Improvement System* document
  - Artificial intelligence and the practice of medicine – the Board received an update and agreed with the general direction and the development of a work plan
  - Streamlined registration – the work is ongoing among six MRAs on a *Fast-Tracked Licensure Agreement* and a *Telemedicine Agreement*; FMRAC work is ongoing on the *License Portability Agreement*
  - Impaired physicians – the draft mandate and the working group composition were **approved**
  - Standardizing the certificate of professional conduct – the Board received an update on work undertaken to date by staff
- Outside organizations and representation, including working with the Federal Government
  - Review of the draft agenda for the June meeting with the Medical Council of Canada on in-practice assessment of physicians
  - Discussion with Royal College representatives and **approval in principle** of the new practice-eligibility route for certification; and a preliminary discussion on changes to the practice-ready assessment
- Corporate activities
  - The *FMRAC Code of Conduct for FMRAC Events* was **approved**
  - The 2020-21 budget was **approved**
  - By-law changes – the Board made two decisions that will require modifications to the by-laws
    - a reduction in the term of office from two years to one for the President-elect (to coincide with the second year of the President's two-year term) and the Immediate Past-President (to coincide with the first year of the President's term)
    - a change in the composition of the Executive Committee to include the President, the Chair of the Audit and Finance Committee and either the President-elect or the Immediate Past-President

Medical Assistance in Dying (MAiD)

Ms. Fleur-Ange Lefebvre represented FMRAC at the Federal Government Roundtable Discussion on MAiD in Ottawa on 24 January 2020. The government representatives were the Hon. Patty Hajdu, Minister of Health,

the Hon. David Lametti, Minister of Justice, the Hon. Carla Qualtrough, Minister of Employment, Workforce Development and Disability Inclusion as well as their respective Parliamentary Secretaries and Deputy Ministers. There were two rounds for input, one on the Truchon judgement from Québec and resulting changes, and the second one on procedural issues and advance directives. FMRAC delivered the following messages:

- *We support the removal of "reasonably foreseeable natural death" as an inclusion criterion for MAID. We see no need for additional eligibility criteria or procedural safeguards to be added to the legislation. If further legislated safeguards are considered necessary to protect vulnerable populations, we submit that such safeguards must not compromise patient autonomy.*
- *We support removing the requirement for independent witnesses to the assessment of a patient's eligibility by a regulated health professional. In our experience, the requirement compromises or complicates access, and infringes on a patient's right to privacy and confidentiality.*
- *We support the inclusion of language that allows for the delivery of MAID to a patient who has lost capacity after having been found eligible and provided consent to receive MAID.*
- *We propose that the broader question of advance directives or advance requests for patients who have not as yet been found to be eligible for MAID be tabled for further consultation in a timely manner.*
- *We support the adoption of specific language in the Act to make clear that informing patients of the availability of MAID is not considered counselling for MAID.*
- *We support clarifying the legislation in a manner that expressly permits patients to consent to either or both modes of administration, enabling clinicians to intervene should a patient's attempt at self-administration not be successful.*
- *In addition, FMRAC strongly believes we must all acknowledge that it is important that all Canadians have access to palliative and end-of-life care; currently, this aspect of health care is significantly under-resourced.*

International Association of Medical Regulatory Authorities (IAMRA) – *2022 International Conference on Medical Regulation*

Pending final approval by the IAMRA Management Committee, FMRAC and the Federation of State Medical Boards (U.S.) will co-sponsor and co-host the 2022 IAMRA conference in Vancouver, BC from 12-15 September 2022. The Board agreed that FMRAC will contribute a maximum of $25,000 CDN (plus applicable taxes) and staff time and travel. FMRAC has secured support from the MCC ($7,500) and the Royal College (amount pending).

FMRAC Annual Meeting and Conference – 5-9 June 2020 in Halifax, NS

The Educational Conference program will feature three discrete half-days on the following topics : a) pan-Canadian registration; b) private, uninsured medicine; and c) artificial intelligence and the role of medical regulation.

Highlighting one Organizational Priority – *Framework for FMRAC's Members on a Regulatory Approach to Physicians Who Prescribe Opioids (February 2020)*

This framework required several rounds of consultation with the MRAs and a broad group of external stakeholders who provided significant and very diverse feedback. The Board thanked Dr. Karen Mazurek (Working Group Chair and soon-to-be-retired Deputy Registrar, CPSA) and Ms. Louise Auger, Director of Professional Affairs for the skillful way in which they handled and, where appropriate, incorporated the diverse feedback and expectations of the external stakeholders.

The English version of the approved framework can be found at:
https://fmrac.ca/prescription-opioids/

The French version will be posted in the very near future.

MISSION

To advance medical regulation on behalf of the public through collaboration, common standards and best practices.

PILLARS

The following six pillars will enable FMRAC to achieve this mission as proactively and creatively as possible:	
P1	*establish mechanisms for the effective exchange of information, discussion and collaboration with its members and others, on issues that involve medical regulation*
P2	*develop policies, standards, statements and perspectives on aspects of medical regulation – either pan-Canadian or drafts that can be adapted by the members*
P3	*actively participate in the design and coordination of pan-Canadian health system changes*
P4	*be an effective voice to interact with and inform key stakeholders (including governments, the public and media) on medical regulatory matters of national or international importance*
P5	*develop and maintain programs, services and benefits for its members*
P6	*identify and mitigate risk to medical regulation in a timely manner*

CORE ACTIVITIES

C1	*advocacy and common voice – where FMRAC stands publicly and speaks on behalf of the medical regulatory authorities of Canada* ▪ *at the federal level* ▪ *with the members, the public and the media – promote pan-Canadian standards, even if they are aspirational, especially when members can use them in discussions with their own governments* ▪ *with other national organizations – promote the notion of public interest regulation*
C2	*surveillance of political developments and trends that may have an impact on the work of the Members in fulfilling their mandate*
C3	*the FMRAC Integrated Risk Management System (FIRMS)*
C4	*Model Standards for Medical Registration in Canada*

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

COUNCIL MEETING – MARCH 13, 2020

ITEM FOR INFORMATION

EXECUTIVE COMMITTEE REPORT:

The full Executive Committee met on January 8, 2020, February 5, 2020. A panel of the Executive Committee met on February 12, 2020 for an appeal hearing. Most of the matters dealt with by the Executive Committee are included on the agenda for this meeting of Council, so will not be reiterated.

- **Hearing Appeal of Interim Terms and Conditions**

  At the December Council meeting, the Executive Committee reported that on September 30, 2019 it heard the matter of an appeal of the Investigation Committee imposing interim terms and conditions upon a physician. A decision was still pending on that matter in December. Since then the Investigation Committee decision upholding the Interim Terms and Conditions was upheld.

- **Application for Reinstatement**

  The Executive Committee met to consider an application for reinstatement from a physician who has applied previously on several occasions unsuccessfully. This time the Executive Committee did not hear or consider on its merits the matter of that physician's application for reinstatement on the basis of *res judicata* (decision was previously decided) and abuse of process (re-arguing the case is abusive) and dismissed the application without a hearing.

- **Appeal of Investigation Committee Decision Hearing**

  There was one appeal of a decision of the Investigation Committee heard by a panel of the Executive Committee. The decision of the Investigation Committee was confirmed.

AUDIT & RISK MANAGEMENT COMMITTEE REPORT:

- **January 31, 2020 Quarterly Financial Statements**
  - Management presented the January 31, 2020 quarterly financial statements of the College. At the end of the 3rd quarter CPSM has posted a surplus of $285,000, which is an increase from the original budgeted deficit of $6,000.
  - This positive variance has resulted from lower than anticipated expenses for this period as well as higher than expected revenues.
  - The April 30, 2020 audited financial statements of the College will be presented to Council at the June 2020 AGM.

- **Audit & Risk Management Committee – Terms of Reference (TOR)**
  - The Committee heard from management that the current TOR was outdated and needed to be reviewed and updated to accurately reflect the present responsibilities of this committee. Management had conducted an in-depth review of the TOR – including a survey of other Colleges across the country in regard to their own Audit Committees to identify any gaps as well as key opportunities for improvement.
  - After lengthy discussion – the committee directed management to draft an amended TOR for consideration and approval at the May 2020 committee meeting. Once completed – the TOR will be brought forward to Council for approval at the June 2020 meeting.

- **Information Technology update**
  - The committee received an IT update from management which included a summary of the significant measures undertaken to review and provide an analysis of the current CPSM IT environment.
  - Over the past 12-18 months – several measures have been initiated in an effort to increase the efficiency and effectiveness of this critical support function at the College.
  - CPSM current IT resources, external IT service providers and IT security were all included in this analysis. IT budgeted savings realized as a result of these initiatives were also presented to the committee indicating a net savings to CPSM in the amount of $377,000.

Respectfully submitted,
Dr. Jacobi Elliott
Chair, Audit & Risk Management Committee

COMPLAINTS COMMITTEE REPORT:

Complaint Received	Total Cases
May/2019	17
June/2019	10
July/2019	11
August/2019	8
September/2019	3
October/2019	19
November/2019	12
December/2019	6
January/2020	11
February/2020	5
Grand Total	102

Length of time required to acknowledge complaints received
between 01-May-2019 and 19-Feb-2020

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Complaints Acknowledge In	Total Cases
	6
2 days or less	70
3-5 days	15
6-10 days	7
Greater than 10 days	4
Total number of complaints cases in time period:	102

Length of time required to resolve complaints for cases closed between 01-May-2019 and 19-Feb-2020

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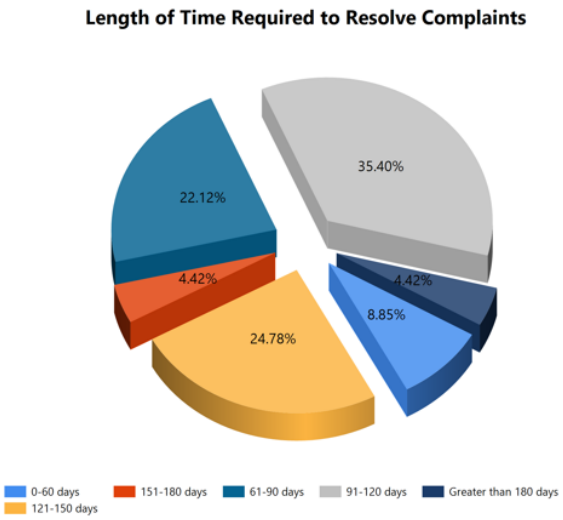
Complaints Cases with	Total
0-60 days	10
61-90 days	25
91-120 days	40
121-150 days	28
151-180 days	5
Greater than 180 days	5
	113



Respectfully submitted,
Dr. Heather Smith
Chair, Complaints Committee

INVESTIGATION COMMITTEE REPORT:

The department continues to be very busy with 66 active investigations. We are in the midst of two Inquiry Hearings.

Several staff are involved in the Boundary Violations Working Group (this group will be reporting separately)

New materials for letters and information brochures are being developed for communication with the public.

We are reviewing and updating IC policies

Dr. Bullock-pries and Dr. Campbell are going to the College in Ontario in April, 2020 to learn more about their mediation process so we could start implementing it in our complaint resolution process.

Respectfully submitted,
Dr. Nader Shenouda
Chair, Investigations Committee

PROGRAM REVIEW COMMITTEE REPORT:

Program Review has been meeting dealing with its usual MANQAP lab and imaging site accreditation duties as well as non-hospital medical/surgical facilities reviews. This role will likely expand with revisions to the criteria determining which procedures require site inspections, as being determined by the Accredited Facilities Working Group and subsequent Bylaw revisions.

Issues remaining unresolved include the future location of MANQAP, given the previous Council divestment directive and unchanged service purchase agreement funding.

Respectfully submitted,
Dr. Wayne Manishen
Chair, Program Review Committee

QUALITY IMPROVEMENT COMMITTEE REPORT:

The Quality Improvement (QI) Committee convened on February 13, 2019. The committee was debriefed on program activities, including one action taken on behalf of the QI committee since the meeting of September 17, 2019. Two files, both of which received previous recommendations for six months' follow up off-site chart reviews, were brought forward for review and discussion. The committee recommended the following: 1. Case one- a follow up interview with the Assistant Registrar to address barriers to quality improvement, plus further action in the form of an interactive, on-site review; 2. Case two- recommendations for continuing professional development coaching plus follow up chart review in six months. Two policies were brought forward for review and approval. The Leaving the Province Policy was approved as written, and the Participation in the Program Policy was approved post in camera revisions.

The Quality Improvement Program launched three intakes, encompassing 294 family physicians in 2019. As of February 13, 2020, 194 members were deemed eligible to participate. As of February 13, 2020, 183 participants have completed the process. The remaining participants are scheduled to receive either an off-site or on-site review. All reviews will be completed by the first quarter of 2020. A fourth intake was initiated in January 2020, with another 159 participants entering the process. The first specialist cohort of 30 psychiatrists is expected to commence in March 2020.

The committee was debriefed on a decision made by the QI Committee chair to refer a file to the Central Standards Committee for retrieval of a chart for review. This was in response to concerns flagged of a specialist's care arising from a QI audit of a family physician. The committee also deliberated on recommendations regarding noncompliance with the Quality Improvement Program. A policy will be drafted regarding non-compliance and will be brought forward to the next meeting for review by the committee. In the interim, one case will be referred to Central Standards Committee for review due to program non-compliance.

The Quality Improvement Committee discussed its future role as a subcommittee. It was determined that members be offered time to reflect on the committee's role and respond to the chair with recommendations. These recommendations will be brought forward as a separate communication to Council. The next meeting is scheduled for April 16, 2020.

Respectfully submitted,
Dr. Christine Polimeni
Chair, Quality Improvement Committee

STANDARDS COMMITTEE REPORT:

The Standards Committee has not met since the last Council meeting and will meet on Friday, February 28, 2020 after the agenda deadline therefore a verbal report will be given at Council.

Respectfully,
Dr. Roger Suss
Chair, Central Standards Committee

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SELF-EVALUATION OF COUNCIL

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

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

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