CPSO

Meeting of Council

March 6, 2020

CPSO

NOTICE

OF

MEETING OF COUNCIL

A meeting of the College of Physicians and Surgeons of Ontario will take place on Friday, March 6, 2020 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 am.

Nancy Whitmore, MD, FRCSC, MBA
Registrar and Chief Executive Officer

February 11, 2020

MEETING OF COUNCIL

March 6, 2020

Council Chamber, 3rd Floor, 80 College Street, Toronto

CALL TO ORDER

9:00 **Welcome and Introductions**

9:30 **1.** **Draft Council Minutes of December 5 and 6, 2019 ..... 1**

- ***For Approval***

FOR INFORMATION

9:32 **2.1** **Executive Committee Report 24**

2.2. **Government Relations Report 25**

2.3. **Discipline Committee Report of Completed Cases, November 18, 2019 to February 13, 2020 ..... 29**

2.4. **Policy Report 61**

2.5. **Governance Committee Report 67**

9:35 **3.** **Acceptance of Academic Representative to Council 73**

- ***For Decision***

Council is asked to accept a recommendation from the *Academic Advisory Committee* for Dr. Janet van Vlymen, academic representative from Queen's University, to fill a vacancy for one voting Academic Representative on Council.

9:40 4. Election for Vice President on the Executive Committee for 2020 75

- ***For Decision***

There is a current vacancy for the position of Vice President on the 2020 Executive Committee. A vote will take place at the March 6 meeting of Council to fill the vacancy for Vice President, and, if applicable, to fill one vacancy for an Executive Member Representative of Council.

10:00 5. Council Orientation to CPSO ..... *(no materials)*

- ***For Information/Discussion***
  - Overview of CPSO
  - Strategic Plan and Key Performance Indicators
  - Leadership Team and Key Accountabilities
  - Transformation Initiatives

10:25 BREAK

10:45 6. Registrar/CEO's Report ..... *(no materials)*

11:30 7. President's Report ..... *(no materials)*

11:35 8. Application Health Questions – Management and Messaging 89

- ***For Discussion***

Council is provided with an overview of the College's approach to the management of health-related questions and information arising out of the College's application process.

COUNCIL AWARD PRESENTATION

11:45 9. Council Award Recipient: Dr. Steven Griffin, Bancroft, Ontario 93

12:00 LUNCH BREAK

1:00 In Camera Session

1:00 10. Medical Records 94

- ***For Decision***

The College's *Medical Records* policy is currently under review. In September 2019, Council released two new draft medical records policies, retitled *Medical Records Stewardship* and *Medical Records Documentation,* for external consultation. The draft policies have been revised in light of the feedback received through this engagement activity. Council is provided with an overview of the changes and is asked whether the revised draft policies can be approved as policies of the College.

1:20 11. Protecting Personal Health Information 132

- ***For Decision***

The College's *Confidentiality of Personal Health Information* policy is currently under review. A new draft policy, entitled *Protecting Personal Health Information*, was released for external consultation over the fall and has now been revised to reflect the consultation feedback received. Council is asked whether the revised draft policy is approved as a policy of the College.

1:40 12. Advertising Policy 157

- ***For Decision***

A draft *Advertising* policy has been developed to help provide clarity or address areas of ambiguity with respect to the expectations for physician advertising set out in the General Regulation under the *Medicine Act, 1991 (*O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30) (the Regulation). A companion *Advice to the Profession* document has also been developed to offer further guidance to physicians. Council is provided with an overview of the draft policy and advice document and is asked whether the draft policy can be released for external consultation and engagement.

2:00 13. Medical Assistance in Dying - Update 172

- ***For Discussion***

In September 2019 the Superior Court of Quebec struck down one of the eligibility requirements for accessing medical assistance in dying (MAID) in Canada, namely, the requirement that a person's natural death be reasonably foreseeable.

The federal government opted not to appeal this decision, choosing instead to respond through legislative change in advance of the March 2020 deadline set by the Court. A public consultation was held to inform this legislative work in January 2020.

Council is provided with a brief overview of the Court decision, the College's

involvement in the federal government's consultation processes and anticipated next steps in the process.

2:10 14. Member Topics

Dr. Philip Berger's Motion 177

- ***For Decision***

2:25 BREAK

2:45 15. CPSO Relationship with Health System Stakeholders ..... *(no materials)*

- ***For Discussion***

An overview will be provided regarding the various health system stakeholders that CPSO works with to achieve the strategic objectives outlined in the Strategic Plan. Council members are invited to share perspectives and suggestions to enhance system collaboration.

3:15 16. By-Law Amendments

16.1 Fees and Remuneration 180

- ***For Decision***

At the Council meeting in December of 2019, Council proposed to make changes to the Fees and Remuneration By-Law as recommended by the Finance and Audit Committee. As required, the by-law was circulated to the profession and is now coming back for final approval.

16.2 Council Election Recount Request Period 183

- ***For Decision***

Council is being asked to approve by-law amendments to shorten the period for requesting a recount of the results of Council elections. As required, the by-law was circulated to the profession and is now coming back for final approval.

3:25 17.1 Committee Appointments – Vice President 186

- ***For Decision***

As a result of the election for Vice President, Council may be asked to make consequential and additional committee appointments at the March 6, 2020 Council meeting.

17.2 Committee and Chair Appointments 187.1

- ***For Decision***

Council will consider committee and chair recommendations made by the Governance Committee on February 24, 2020.

3:30 18. Succession Planning - Requests for Exceptional Circumstances 188

- ***For Decision***

The 9-year and 18-year term limits will be applied to Committees beginning in 2020. To support the implementation process, Committee Chairs have developed succession plans and have made requests to use the exceptional circumstances provision for select Committee members they feel are critical for an effective transition.

3:45 ADJOURNMENT

Council Motion

Motion Title: Council Meeting Minutes of December 5 and 6, 2019

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

The Council accepts the minutes of the meeting of the Council held on December 5 and 6, 2019

or

The Council accepts the minutes of the meeting of the Council held on December 5 and 6, 2019 with the following corrections:

DRAFT PROCEEDINGS OF THE
MEETING OF COUNCIL OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
DECEMBER 5 AND 6, 2019

December 5, 2019

Attendees:

Dr. Peeter Poldre (President)
Ms Hilary Alexander
Dr. Philip Berger
Mr. Shahid Chaudhry
Dr. Brenda Copps
Mr. Harry Erlichman
Ms Joan Fisk
Dr. Michael Franklyn
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Paul Hendry
Mr. Mehdi Kanji
Ms Catherine Kerr
Mr. John Langs
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms Ellen Mary Mills
Ms Judy Mintz
Mr. Peter Pielsticker
Dr. Judith Plante
Ms Joan Powell
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Robert Smith
Ms Gerry Sparrow
Ms Christine Tebbutt
Dr. Andrew Turner
Dr. Scott Wooder

Non-voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Janet van Vlymen

Regrets:
Dr. Deborah Hellyer, Dr. Akbar Panju

CALL TO ORDER

President's Announcements

Dr. Poldre called the meeting to order at 9 am and welcomed members and guests. He opened the meeting with a traditional land acknowledgement statement as a demonstration of recognition and respect for indigenous peoples.

1. COUNCIL MEETING MINUTES OF SEPTEMBER 20, 2019

01-C-12-2019

It is moved by Mr. Shahid Chaudhry and seconded by Dr. Jerry Rosenblum that:

The Council accepts the minutes of the meeting of the Council held on September 20, 2019.

CARRIED

2. FOR INFORMATION

The following reports were received for information:

2.1 Executive Committee Report

2.2 Government Relations Report

2.3 Policy Report

2.4 Discipline Committee Report of Completed Cases

2.5 Interventional Pain Management Change of Scope

2.6 Annual Committee Reports

Discipline Committee

Education Committee

Executive Committee

Governance Committee

Inquiries, Complaints and Reports Committee

Outreach Committee

Patient Relations Committee

Premises Inspection Committee

Quality Assurance Committee

Registration Committee

3. REGISTRAR/CEO REPORT

Dr. Nancy Whitmore reported on a number of highlights from the 2019 year, including Right-Touch Regulation, and, how adopting the approach has seen efficiencies realized in the College's complaints process. The changes include: the number of early resolution cases has increased by 88%; Complaint investigations opened in the first six months are being completed

44% faster than during the same period last year; the number of closed complaints has outnumbered new complaints in the past five quarters; the number of ongoing cases has dropped by half since the start of 2018; the time it takes to write an ICRC decision has dropped by 85% since June 2018; and the time it takes to release a discipline decision has dropped by 51%.

Dr. Whitmore also updated Council on the successful completion of the Quality Improvement pilot and described how the College significantly increased public and patient engagement.

A copy of Dr. Whitmore's presentation is attached as **Appendix "A"** to these minutes.

4. STRATEGIC PLAN KEY PERFORMANCE INDICATORS (OPTIMUS)

02-C-12-2019

It is moved by Ms Joan Fisk and seconded by Dr. Patrick Safieh that:

The Council adopts the following Key Performance Indicators (KPIs) to measure and report progress on the 2020-2025 Strategic Plan:

1. **Complaints completed within 150 days**
2. **Complaints responded to within 2 business days**
3. **Time from referral to Discipline Committee to first hearing**
4. **Investigations that are resolved through early resolution process**
5. **Physicians selected for assessment based on age risk factors**
6. **Physicians who engaged in the QI program**
7. **Engagement meetings conducted with public and patients**
8. **Engagement meetings conducted with the profession**
9. **Engagements completed by both professional and public members of Council**
10. **Collaborations with health system organizations**
11. **Process improvements per employee**

CARRIED

5. DISCLOSURE OF HARM POLICY

03-C-12-2019

It is moved by Dr. Philip Berger and seconded by Dr. Robert Smith that:

The Council approves the revised policy "Disclosure of Harm", (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

6. COUNCIL AWARD PRESENTATION

Ms Ellen Mary Mills presented the Council Award to Dr. Michelle Hladunewich of Toronto.

7. EDUCATION SESSION SHARED LEARNINGS FROM A GOVERNANCE REVIEW

Deanna Williams is the President of Dundee Consulting Group Ltd, a non-profit group consulting in governance, organization culture and change, strategic planning and negotiation, with expertise in professional and occupational regulation. Using a case example, Ms Williams shared learnings regarding governance best practices following a review of a health regulatory college that she conducted. A copy of Ms Williams' presentation, "Good Governance Informing Modernization" is attached as Appendix "C" to these minutes.

8. BOUNDARY VIOLATIONS – REVISED POLICY FOR FINAL APPROVAL

04-C-12-19

It is moved by Ms Ellen Mary Mills and seconded by Mr. Mehdi Kanji that:

The Council approves the revised policy "Boundary Violations", formerly titled "Maintaining Appropriate Boundaries and Preventing Sexual Abuse", (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

9. PRESCRIBING DRUGS – REVISED POLICY FOR FINAL APPROVAL

05-C-12-19

It is moved by Mr. Pierre Giroux and seconded by Ms Joan Fisk that:

The Council approves the revised policy "Prescribing Drugs", (a copy of which forms Appendix "E" to the minutes of this meeting).

CARRIED

10. MOTION TO GO IN CAMERA

06-C-12-19

It is moved by Dr. Patrick Safieh and seconded by Dr. Judith Plante that:

The Council exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code.

CARRIED

ADJOURNMENT DAY 1 OF 2

The meeting adjourned at 3:05 pm.

December 6, 2019

Present:

Dr. Peeter Poldre (President)
Ms Hilary Alexander
Dr. Philip Berger
Mr. Shahid Chaudhry
Dr. Brenda Copps
Mr. Harry Erlichman
Ms Joan Fisk
Dr. Michael Franklyn
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Paul Hendry
Mr. Mehdi Kanji
Ms Catherine Kerr
Mr. John Langs
Dr. Haidar Mahmoud
Mr. Paul Malette *(attended afternoon only)*
Ms Ellen Mary Mills
Ms Judy Mintz
Mr. Peter Pielsticker
Dr. Judith Plante
Ms Joan Powell
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Robert Smith
Ms Gerry Sparrow *(attended afternoon only)*
Ms Christine Tebbutt
Dr. Andrew Turner
Dr. Scott Wooder

Non-voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Janet van Vlymen

Regrets:
Dr. Deborah Hellyer, Dr. Akbar Panju

CALL TO ORDER

President's Announcements

Dr. Poldre called the meeting to order at 10:30 am.

11. REPORT OF THE FINANCE AND AUDIT COMMITTEE

Proposed by-law amendment to the General By-Law 1 – Signing Authorities

07-C-12-19

It is moved by Mr. John Langs and seconded by Dr. Patrick Safieh that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 131:

By-law No. 131

1. **Section 1a of the General By-law is revoked and the following is substituted:**

1a. Except as provided otherwise in section 4 of this By-Law, contracts, agreements, instruments and other documents shall be signed on behalf of the College by the registrar/chief executive officer, a deputy registrar or chief transformation officer.

2. **The General By-law is amended by adding the following as subsection 1c:**

Legal Review

1c. Contracts, agreements, instruments and other documents are subject to review by the Legal Office in accordance with internal College agreement and contract management policy.

3. **Subsection 2(2) is revoked and the following is substituted:**

(2) The executive committee may by resolution decide to invest or reinvest funds of the College that are not immediately required in any investment which the executive committee considers advisable, and two signing officers (as defined in subsection 4(7)) shall implement the decision.

4. **Section 3 of the General By-law is revoked and the following is substituted:**

Borrowing

3. (1) The council may by resolution,

(a) **borrow money on the credit of the College, except that a Council resolution is not required for the College to borrow amounts not exceeding $100,000 in total,**

(b) **limit or increase the amount or amounts to be borrowed, and**

(c) **secure any present or future borrowing, or any debt, obligation, or liability of the College, by charging, mortgaging, hypothecating or pledging all or any of the real or personal property of the College, whether present or future.**

(2) The executive committee shall not exercise the powers or duties of the council under subsection (1) or take any similar action, despite the authority granted to the executive committee in section 30 (Executive Delegation).

(3) The council or the executive committee may by resolution borrow money on behalf of the College for periods of six months or less secured only by investments of the College of the type mentioned in subsection 3(1).

(4) Two signing officers shall sign documents to implement a decision made under subsection (1) or subsection (3).

5. Section 4 of the General By-law is revoked and the following is substituted:

Expenses

4. (1) Goods may be purchased or leased, and services may be obtained, for the benefit of the College if the purchase, lease or obtaining of services is authorized by, and except as provided in subsection 4(2)(b), any contract or agreement for or relating to such purchase, lease or services shall be signed by,

(a) **a signing officer (as defined in subsection 4(7)) if the expenditure is authorized by the College budget;**

(b) **a signing officer if the resulting obligation does not exceed $100,000 and the expenditure is not authorized by the College budget;**

(c) **two of the registrar, a deputy registrar, chief transformation officer or corporate services officer if the resulting obligation exceeds $100,000 but does not exceed $250,000 and the expenditure is not authorized by the College budget;**

(d) **after conferring with the chair of the finance and audit committee, one of the registrar, a deputy registrar, chief transformation officer or corporate services officer and one of the president or vice-president, if the resulting obligation exceeds $250,000 and the expenditure is not authorized by the College budget; or**

(e) **the executive committee or the council, by resolution.**

(2) Two signing officers shall sign,

(a) **a cheque or authorize an electronic transfer of funds for payment for goods purchased or leased, or services obtained, in accordance with subsection (1); and**

(b) **a contract, agreement or other document for or relating to the purchase, lease or obtaining of services authorized by the council or the executive committee by resolution.**

(3) Without derogating from the authority under subsection (1) to obtain legal services, legal advice or representation may be obtained for the benefit of the College,

(a) **if the resulting obligation is authorized by the College budget, by the administrative head of the College's legal office; or**

(b) **that is not authorized by the College budget, by the administrative head of the College's legal office with the concurrence of,**

(i) one of the registrar or a deputy registrar; and

(ii) one of the president or the vice-president after conferral with the finance and audit committee.

(4) Two signing officers shall sign a cheque or authorize an electronic transfer of funds for legal services obtained in accordance with subsection (3).

(5) Two signing officers shall sign a salary cheque for an employee of the College or authorize salary payment to an employee of the College by means of electronic transfer of funds to the employee's bank account.

(6) Despite subsection 4(2), an offer of employment or an agreement for employment with the College, which employment position is authorized by the College budget, shall be signed by the director or associate director of the department in which the employee is to be working, the manager responsible for hiring the employee, the associate director of Human Resources, the chief transformation officer, the registrar or a deputy registrar.

(7) For purposes of Part 1 of the General By-law, the term "signing officer" means any of the following: the registrar, a deputy registrar, the chief transformation officer, the corporate services officer, the manager of finance and the corporate accountant. A person listed as a signing officer in subsection 4(7) may not sign a cheque or authorize an electronic transfer of funds payable to such person.

(8) Despite subsections 4(2) and 4(6), an agreement for employment of the registrar shall be signed on behalf of the College by one of the president or the vice-president.

CARRIED

2020 Budget

08-C-12-19

It is moved by Mr. Pierre Giroux and seconded by Mr. Shahid Chaudhry that:

The Council approve the "Budget for 2020" (a copy of which forms Appendix "F" to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2020.

CARRIED

Fees By-Law Amendment – Council and Committee Remuneration

09-C-12-19

It is moved by Ms Christine Tebbutt and seconded by Mr. Pierre Giroux that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 135:

By-law No. 135

(1) Paragraph 20(3) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted, effective January 1, 2020:

(3) The amount payable to members of the council and a committee is, subject to subsections (4) and (8),

(a) for attendance at, and preparation for, meetings to transact College business, $510 per half day, and

(b) for transacting College committee business by telephone or electronic means of which minutes are taken, the corresponding hourly rate for one hour and then the corresponding half hour rate for the half hour or major part thereof after the first hour.

(2) Paragraph 20(8) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following are substituted:

(8) The amount payable to the president under subsection 20(3)(a) applies to the following College business:

(a) Council meetings,

(b) meetings of committees which the president is required to attend,

(c) policy working groups,

(d) outreach and other speaking engagements coordinated by the College, but not including stakeholder meetings outside the College and government relations meetings, and

(e) conference attendance.

For all other College business conducted by the president (including but not limited to, stakeholder meetings outside the College and government relations meetings), the College shall pay the president a stipend in the annual amount authorized in the College budget, or if the president is unable or unwilling to serve any part of the term as president, a pro rata amount for the time served.

CARRIED

10-C-12-19

It is moved by Ms Judy Mintz and seconded by Dr. Elizabeth Samson that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 132, after circulation to stakeholders:

By-law No. 132

a. Sections 14, 15 and 16 of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked.

CARRIED

President's Stipend

Council approved an increase in the President's Stipend to $37,500 per year. This amount was included in the 2020 budget.

Compensation Based on Scheduled Meeting Time

This matter was received for information.

12. MEMBER TOPICS

12.1 OMSA and PARO Observers

Dr. Poldre introduced two medical learners invited to attend the Council Meeting as observers: Ms Debbie Brace, representing the Ontario Medical Students Association (OMSA) and Dr. Tracy Sarmiento, representing the Professional Association of Residents of Ontario (PARO).

12.2 Proposal to Retain an External Expert

11-C-12-19

It is moved by Dr. Philip Berger, and seconded by Dr. Michael Franklyn, that the following motion be discussed at the next Meeting of Council:

The Council directs that the CPSO Executive Committee retain within 1 month of Council's approval of this motion an external expert form either the Judiciary or the Bar to make and deliver to Council, within 6 months of Council's approval of this motion, recommendations on the CPSO deliberative processes respecting patient care; the recommendations to include the following:

Guidelines to guarantee the independent gathering, with appropriate thoroughness, of reliable information from all relevant sources and of opinion from all relevant parties;

Guidelines on how to appropriately and transparently weigh that information and opinion in the course of the CPSO deliberative processes;

Guidelines to forestall any undue influence, apparent or real, of any party external to the CPSO so that the transparency and independence of the CPSO are upheld; and

General advice on sustaining the CPSO's primary duty to serve and protect the public interest.

CARRIED

13. DISTRICT COUNCIL ELECTIONS

13.1 District Election Dates

12-C-12-19

It is moved by Dr. Patrick Safieh, and seconded by Mr. Peter Pielsticker, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 133:

By-law No. 133

1. Section 12 of the General By-law is revoked and the following is substituted:

Election Date

12. (1) A regular election shall be held in,

(a) **May or June 2020, and in every third year after that for Districts 5 and 10;**
(b) **May or June 2021, and in every third year after that for Districts 6, 7, 8 and 9; and**
(c) **May or June 2022, and in every third year after that for Districts 1, 2, 3 and 4.**

(2) Subject to subsection (1), the council shall set the date for each election of members to the council.

CARRIED

13.2 2020 District Election Date

13-C-12-19

It is moved by Dr. Philip Berger and seconded by Dr. Paul Hendry, that:

The Council approves the 2020 District election date set out below:
Districts 5 and 10: June 9, 2020

CARRIED

13.3 Election Recounts

14-C-12-19

It is moved by Dr. Jerry Rosenblum and seconded by Dr. Judith Plante, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 134, after circulation to stakeholders:

By-law No. 134

(1) Section 21 of the General By-law is revoked and the following is substituted:

Recounts

21. (1) A candidate may require a recount by giving a written request to the registrar no more than three business days after the date of an election and paying a fee of $500.

(2) The registrar shall hold the recount no more than thirty days after receiving the request.

CARRIED

14. 2018-2019 COUNCIL PERFORMANCE ASSESSMENT

The Council completed the annual performance assessment for 2018-2019. Results from the assessment including strengths and opportunities for improvement were discussed by Council.

PRESIDENT'S TOPICS

15. Presidential Address: Dr. Peeter Poldre

Dr. Peeter Poldre delivered his Presidential Address to Council. He displayed colourful slides of his travels that reflected his Estonian heritage. He then described his year as President, the College's accomplishments, and the challenges that lay ahead.

16. Induction of New President: Dr. Brenda Copps

Dr. Poldre presented Dr. Copps with the President's pin.

Induction of New Members of Council

Dr. Copps presented a Council pin to Dr. Ian Preyra and invited him to take his seat at the Council table.

17. GOVERNANCE COMMITTEE REPORT

17.1 2019-2020 Governance Committee Election

Council elected Dr. Jerry Rosenblum for the single physician member position, and Mr. Mehdi Kanji and Mr. John Langs were acclaimed for the two public member positions.

17.2 Committee Membership Appointments for 2019-2020

15-C-12-19

It is moved by Dr. Peeter Poldre and seconded by Dr. Robert Smith that:

The Council appoints the following people to the following committees for the terms indicated below:

Discipline Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Philip Berger	1 year
Dr. Michael Franklyn	1 year
Dr. Deborah Hellyer	1 year
Dr. Paul Hendry	1 year
Dr. Peeter Poldre	1 year
Dr. Ian Preyra	1 year
Dr. John Rapin	1 year
Dr. Robert (Bob) Smith	1 year
Dr. Andrew Turner	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Pierre Giroux	1 year
Mr. Mehdi Kanji	1 year
Mr. John Langs	1 year
Mr. Paul Malette	1 year
Ms. Ellen Mary Mills	1 year
Mr. Peter Pielsticker	1 year

Ms. Gerry Sparrow	1 year
Ms. Christine Tebbutt	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Ida Ackerman	1 year
Dr. Heather-Ann Badalato	3 years
Dr. Steven Bodley	1 year
Dr. Pamela Chart	1 year
Dr. Carole Clapperton	1 year
Dr. Melinda Davie	1 year
Dr. Paul Garfinkel	1 year
Dr. Kristen Hallett	1 year
Dr. Stephen Hucker	1 year
Dr. Allan Kaplan	3 years
Dr. William L.M. King	1 year
Dr. Barbara Lent	1 year
Dr. Bill McCready	1 year
Dr. Veronica Mohr	1 year
Dr. Joanne Nicholson	1 year
Dr. Terri Paul	1 year
Dr. Dennis Pitt	1 year
Dr. Robert Sheppard	1 year
Dr. Eric Stanton	1 year
Dr. Yvonne Verbeeten	1 year
Dr. James Watters	1 year
Dr. Susanna Yanivker	1 year

Finance and Audit Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	1 year
Dr. Rob Gratton	1 year
Dr. Akbar Panju	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Harry Erlichman	1 year
Mr. Pierre Giroux	1 year
Mr. Peter Pielsticker	1 year
NON-COUNCIL PHYSICIAN MEMBER:	
Dr. Thomas Bertoia	1 year

Fitness to Practise Committee:

PHYSICIAN COUNCIL MEMBER:	
Dr. Deborah Hellyer	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. John Langs	1 year
Ms. Christine Tebbutt	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Steven Bodley	1 year
Dr. Pamela Chart	1 year
Dr. Carole Clapperton	1 year
Dr. Melinda Davie	1 year
Dr. Paul Garfinkel	1 year
Dr. Stephen Hucker	1 year
Dr. Barbara Lent	1 year
Dr. Bill McCready	1 year
Dr. Dennis Pitt	1 year
Dr. Robert Sheppard	1 year
Dr. Eric Stanton	1 year
Dr. James Watters	1 year

Governance Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Brenda Copps	1 year
Dr. Akbar Panju	1 year
Dr. Peeter Poldre	1 year
Dr. Jerry Rosenblum	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Mehdi Kanji	1 year
Mr. John Langs	1 year

Inquiries, Complaints and Reports Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Rob Gratton	1 year
Dr. Haidar Mahmoud	1 year
Dr. Akbar Panju	1 year
Dr. Judith Plante	1 year
Dr. Jerry Rosenblum	1 year
Dr. David Rouselle	1 year
PUBLIC MEMBERS OF COUNCIL:	

Ms. Hilary Alexander	*Until Dec. 19-19*
Mr. Shahid Chaudhry	1 year
Mr. Harry Erlichman	1 year
Ms. Joan Fisk	1 year
Ms. Catherine Kerr	1 year
Ms. Joan Powell	*Until Dec. 31-19*

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Haig Basmajian	1 year
Dr. George Beiko	1 year
Dr. Mary Jane Bell	1 year
Dr. Brian Burke	1 year
Dr. Bob Byrick	1 year
Dr. Anil Chopra	1 year
Dr. Paula Cleiman	3 years
Dr. Nazim Damji	1 year
Dr. Naveen Dayal	1 year
Dr. Mary Jean Duncan	1 year
Dr. Gil Faclier	1 year
Dr. Thomas Faulds	1 year
Dr. Daniel Greben	1 year
Dr. Andrew Hamilton	1 year
Dr. Christine Harrison	1 year
Dr. Elaine Herer	1 year
Dr. Robert Hollenberg	1 year
Dr. John Jeffrey	1 year
Dr. Carol Leet	1 year
Dr. Edith Linkenheil	1 year
Dr. Jane Lougheed	1 year
Dr. Edward Margolin	1 year
Dr. Dale Mercer	1 year
Dr. Robert Myers	1 year
Dr. Anita Rachlis	1 year
Dr. Val Rachlis	1 year
Dr. Michael Rogelstad	1 year
Dr. Karen Saperson	3 years
Dr. Dori Seccareccia	1 year
Dr. Lynne Thurling	1 year
Dr. Anne Walsh	1 year
Dr. Donald Wasylenki	1 year
Dr. Stephen White	1 year

Dr. Stephen Whittaker	1 year
Dr. Lesley Wiesenfeld	1 year
PHYSICIAN MEDICAL ADVISORS:	
Dr. Angela Carol	1 year
Dr. Ben Chen	1 year
Dr. Ted Everson	1 year
Dr. Keith Hay	1 year
Dr. Mary Manno	1 year
Dr. Peter Prendergast	1 year
Dr. Nathan Roth	1 year
Dr. Michael Szul	1 year
Dr. Jim Wilson	1 year

Patient Relations Committee:

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Rajiv Bhatla	1 year
Dr. Heather Sylvester	1 year
Dr. Angela Wang	1 year
Dr. Diane Whitney	3 years
NON-LGIC PUBLIC MEMBERS:	
Ms. Lisa McCool-Philbin	1 year
Ms. Sharon Rogers	3 years

Premises Inspection Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Jerry Rosenblum	1 year
Dr. Andrew Turner	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Peter Pielsticker	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Timea Belej-Rak	3 years
Dr. Steven Bodley	1 year
Dr. Andrew Browning	1 year
Dr. Patrick Davison	1 year
Dr. Bill Dixon	1 year
Dr. Marjorie Dixon	1 year
Dr. Mark Mensour	1 year
Dr. Gillian Oliver	1 year

Dr. Holli-Ellen Schlosser	1 year
Dr. Robert Smyth	3 years
Dr. James Watson	1 year
Dr. Ted Xenodemetropoulos	1 year
NON-LGIC PUBLIC MEMBERS:	
Dr. El-Tantawy Attia, PhD	1 year
Mr. Ron Pratt	1 year

Quality Assurance Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Michael Franklyn	1 year
Dr. Deborah Hellyer	1 year
Dr. Sarah Reid	1 year
Dr. Patrick Safieh	1 year
Dr. Robert (Bob) Smith	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. John Langs	1 year
Mr. Paul Malette	1 year
Ms. Ellen Mary Mills	1 year
Mr. Peter Pielsticker	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Steven Bodley	1 year
Dr. Lisa Bromley	1 year
Dr. Jacques Dostaler	1 year
Dr. Miriam Ghali Eskander	1 year
Dr. Hugh Kendall	1 year
Dr. Ken Lee	1 year
Dr. Meredith MacKenzie	1 year
Dr. Deborah Robertson	1 year
Dr. Ashraf Sefin	1 year
Dr. Tina Tao	1 year
Dr. Smiley Tsao	1 year
Dr. Janet van Vlymen	1 year

Registration Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Akbar Panju	1 year
Dr. Judith Plante	1 year
PUBLIC MEMBERS OF COUNCIL:	

Mr. Harry Erlichman	1 year
Mr. Pierre Giroux	1 year
Mr. Paul Malette	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Bob Byrick	1 year
Dr. Barbara Lent	1 year
Dr. Kim Turner	1 year

CARRIED

17.3. Completion of Annual Declaration of Adherence Form

Received for completion by Council members.

17.4 Governance Modernization

Council was updated on various aspects of Governance Modernization, including:

1. The status of the work of legislative and non-legislative changes to modernize the CPSO's governance structures and practices.
2. By-Law Amendments – Term Limits and Exceptional Circumstances Provision
3. Eligibility Practice Criteria – Update
4. College Advisory Groups - Update

17.5 Council Orientation and Education

Council received an overview of Council Orientation and Education programs and ongoing development.

18. MOTION TO GO IN CAMERA

16-C-12-19

It is moved by Ms Joan Fisk and seconded by Ms Ellen Mary Mills that:

The Council exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code.

CARRIED

ADJOURNMENT DAY 2

The meeting adjourned at 2 pm.

_____

Dr. Peeter Poldre, President

_____

Ellen Spiegel, Recording Secretary

CPSO

Council Briefing Note

March 2020

TOPIC: Executive Committee Report
November 2019 – January 2020
In Accordance with Section 12 HPPC

FOR INFORMATION

November 12, 2019 Executive Committee Meeting

19. Council Award

The Executive Committee approved proposals to modernize the Council Award program to ensure it aligns with the ideal qualities of today's physicians and recognizes the diversity that exists among physicians.

The Executive Committee approved the alignment of the Council Award physician roles with the seven roles identified identified in the CanMEDS 2015 Framework. The current categories – Academic Specialty, Community Specialty, Academic Family Practice, Community Family Practice - do not reflect other considerations such as rural/urban experience, early/mid/late career, gender, etc. And depending on the nominations received, it can be challenging at times to ensure that one physician from each of the categories is selected as the Council Award recipient every year. The Executive Committee agreed that removing the current four categories of the Council Award would enable greater flexibility and diversity.

10-EX-Nov-2019 Upon a motion by Steven Bodley, and seconded by Ellen Mary Mills and CARRIED, the Executive Committee approves the proposals to modernize the Council Award program.

Contact: Brenda Copps, President
Lisa Brownstone, x 472

Date: February 13, 2020

Council Briefing Note

CPSO

March 2020

TOPIC: Government Relations Report

FOR INFORMATION

1. Update on the Ontario Legislature
2. Issues of Interest for CPSO
   a) Red Tape Reduction, Governance Modernization and Physician Assistants
   b) BC Consultation on Modernizing Health Regulatory Framework
   c) Public Appointments
   d) Health System Transformation

---

1. UPDATE ON THE ONTARIO LEGISLATURE

- The spring session of the Legislature is scheduled to start on February 18 and end on June 4, 2020.
- In the last session, government continued to focus on reducing red tape and regulatory burdens.
- The government introduced and passed *Bill 116, the Foundations for Promoting and Protecting Mental Health and Addictions Services Act*, that will establish a provincial Mental Health and Addictions Centre of Excellence and support Ontario's participation in a class action lawsuit against opioid manufacturers and wholesalers.
- The government also introduced and passed *Bill 138, the Plan to Build Ontario Together Act*, which amended three pieces of legislation that are of interest to CPSO. Schedule 15 amended the *Health Insurance Act* to enhance the accountability and transparency of OHIP, and Schedule 19 amended the *Independent Health Facilities Act* to enhance the functioning and accountability of Independent Health Facilities. Schedule 30 of Bill 138 also made changes to the *Personal Health Information and Protection Act*, to support the functioning of Ontario Health and Ontario Health Teams.
  - The Ontario Medical Association (OMA) voiced significant concerns about Schedule 15 (*Health Insurance Act*). In response, the government passed numerous amendments to this schedule in Committee, addressing the substantive concerns of the OMA.
- In the final days of the last session, the government introduced *Bill 161, Smarter and Stronger Justice Act*, which would make significant changes to the justice system. Most notably for CPSO, Schedule 14 makes amendments aimed at regulatory burden reduction and process improvement changes at the Law Society, which is of interest to CPSO as we seek to move forward our regulatory and governance reform proposals.

- The government called two byelections in Ottawa-Vanier and Orléans for February 27, 2020. These byelections are needed to replace two Liberal MPPs who stepped down in 2019 – Nathalie Des Rosiers and Marie-France Lalonde.
- On January 16th, former PC MPP Amanda Simard announced that she would be joining the Liberal caucus. Simard left the PC caucus in 2018 to sit as an independent because of her opposition to the government's plan to eliminate the French language commissioner and cancel a planned French-language university (the decision on the university has since been reversed). This brings the total number of Liberal MPPs to six – still short of the twelve seats needed to achieve official party status.
- The Ontario Liberal leadership race is well underway with six candidates. Steven Del Duca is considered to be the front-runner. He represented the riding of Vaughan from 2012-2018 and served as a cabinet minister in the Wynne government. The new leader will be announced the weekend of March 7-8, 2020.
- Outside of the legislature, the government's escalating dispute with teachers has dominated the political landscape. After months of unproductive negotiations and escalating tensions, all four major teachers' unions in Ontario are participating in some form of job action, with rotating one-day strikes occurring at boards across the province.

2. ISSUES OF INTEREST FOR CPSO:

a) Red Tape Reduction, Governance Modernization and Physician Assistants

- Red tape reduction and governance modernization have been areas of focus in our ongoing conversations with government. Overall, feedback on the CPSO's March 2019 submission outlining legislative and regulatory changes has been well received.
- Government Relations staff continue to advocate for the changes contained in our proposal and look for opportunities to move them forward.
- In October 2019, at the Ministry's request, CPSO submitted a renewed proposal to government to regulate Physician Assistants (PAs). The proposal can be found on page 25 of the December 2019 Council Materials.
- We recently received word from government that they are planning to move forward with some form of PA regulation; however, no further details were available at the time this note was written. We will provide Council with additional information as it becomes available.

b) BC Consultation on Modernizing Health Regulatory Framework

- In 2018 the British Columbia Minister of Health appointed Harry Cayton to conduct a review of the College of Dental Surgeons of British Columbia. Cayton's report was released in April 2019, following which a government steering committee was established to provide advice on an approach to modernize the regulatory framework for health professions.

- A consultation paper was released by the steering committee in November 2019 and the paper closed for comments on January 10, 2020. Proposals include:
    - Improving effectiveness of regulatory college boards by ensuring members are appointed based on merit and competence; having equal numbers of registrant and public members; reducing the number of board members (eight to twelve members); and compensating all board members fairly and consistently.
    - Reducing the number of regulatory colleges from 20 to 5.
    - Creating a new body to oversee regulatory colleges.
    - Simplifying and increasing transparency in the complaints and disciplinary process, including creating a new independent disciplinary process.
- The first category of recommendations related to the effectiveness of regulatory college boards is of great interest, given that it mirrors CPSO's recommendations.
- For the most part, the rest of the proposal has not been formerly considered in Ontario, although the BC experience will be instructive given similar trends in the UK and Australia.
- Staff will continue to monitor and report on the next steps of this work in BC.

c) Public Appointments

- Through the fall, CPSO had a full complement of 15 public members of Council. However, between the end of December and into the beginning of February, four public members' terms expired, and one member resigned.
- Another public member's appointment is set to expire on February 16th and, as of the writing of this note, we do not know if they will be renewed.
- Four new public members were recently appointed, Nadia Joseph, Lydia Milian, Jose Cordeiro and Linda Robbins
- This leaves CPSO at the statutory minimum of 14 public members.
- Staff have been in regular contact with the government regarding the importance of timely appointments and the need to ensure that public members of Council have the required skills and availability.
- In response to interest from public members, CPSO staff facilitated a meeting with the Ministry on December 5, 2019 to discuss challenges that they have been experiencing (i.e. payment, appointment process, lack of communication) and identify potential solutions to address their concerns. This meeting also provided an opportunity to identify process changes, both internally, and in our dealings with the Ministry.
- Following this meeting, a letter was written to the Health Board Secretariat requesting retroactive payment for preparation time on CPSO policy working groups. Unfortunately, the Ministry declined this request for reimbursement. Staff will continue to pursue opportunities to seek fair compensation for public members.

d) Health System Transformation

- Matthew Anderson has been announced as the new President and CEO of Ontario Health, effective February 1, 2020. Mr. Anderson was the President and CEO of Lakeridge Health and has previously held senior positions with the University Health

Network, the Toronto Central Local Health Integration Network, and the William Osler Health System.

- On December 10, 2019, the full list of the first 24 Ontario Health Teams was announced. The government has committed to announcing new teams on an ongoing basis.

Contact: Laurie Cabanas, ext. 503
Miriam Barna, ext. 557
Heather Webb, ext. 753

Date: February 13, 2020

Discipline Committee
Report of Completed Cases – March 2020 Council

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between November 18, 2019 and February 13, 2020. The decisions are organized according to category, and then alphabetically by physician last name.

Sexual Abuse – 1 case

1. **Dr. Schwarz**

Name:	Dr. Peter Robert Schwarz
Practice:	Family Medicine
Practice Location:	Sault Ste. Marie
Hearing:	Contested allegation of sexual abuse (Patient A) Admitted allegation of disgraceful, dishonourable or unprofessional conduct (Nurse A, B, C) Contested Penalty
Finding Decision Date:	March 8, 2019
Written Decision Date:	March 8, 2019
Penalty and Costs Decision Date:	December 2, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

On March 8, 2019, the Discipline Committee found that Dr. Peter Robert Schwarz committed an act of professional misconduct, in that he engaged in sexual abuse of a patient; and in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Sexual Abuse and Disgraceful, Dishonourable or Unprofessional Conduct regarding Patient A

Patient A testified that she had seen a specialist about a problem with her cervix and had had an abnormal Pap test and had a subsequent loop electrosurgical excision procedure (LEEP) and "cone" procedure. She understood there were cancer cells present and that she had an HPV infection. She "Googled" information about HPV and realized the virus could also be in her mouth as it was sexually transmitted.

Patient A testified that subsequently, she went to see her dentist and asked him to check her mouth for HPV related lesions. She said her dentist became embarrassed because she told him that she enjoyed giving oral sex. She found his embarrassment and discomfort to be amusing. She stated she was not trying to embarrass the dentist and was trying to make light of the situation. The dentist checked her mouth and found no HPV related problems.

Patient A described a visit to Dr. Schwarz on October 2, 2015. She testified that during that visit, she told Dr. Schwarz about the dental visit and that the dentist was embarrassed. She stated that Dr. Schwarz laughed and as she was preparing to leave, he said that "it's funny he (the dentist) was embarrassed and it's funny that you like doing that."

Patient A testified that Dr. Schwarz opened the door for her and she left the room first and as she entered the hallway she replied, "not any more and you are lucky I have self-control." Patient A testified that her comment "not any more" meant "I don't like oral sex anymore". The second part of her comment, "you are lucky I have self control" was intended as a joke and a comeback. She did not mean it literally but the comment implied that she would give him oral sex. Patient A testified that she had never made a sexual joke to Dr. Schwarz before and neither had he made a sexual joke to her.

Following the October 2, 2015 appointment, Patient A described having her blood work done as ordered by Dr. Schwarz. She testified that she received a phone call from Dr. Schwarz's secretary on October 15th saying that the doctor wished to see her and giving her an appointment for Tuesday the 20th of the next week (five days later). She became very worried that this meant her laboratory tests were abnormal. She decided not to wait and so attended as a walk-in patient the next day, October 16, 2015.

Patient A testified that Dr. Schwarz seemed more casual than usual when he came into the room for the appointment. He greeted her by her last name, which was unusual. He rubbed her back and said to her "don't talk like that in the hallway, someone might hear you". This was in reference to the remarks about oral sex she made at that previous appointment. Patient A testified that she then asked about her blood work and he said it was okay. He told her that the specialist wanted her to have the HPV vaccine and to stop smoking. She found this unusual, as she was already aware of the specialist's opinion. She then asked about her cholesterol and he said it was okay and asked her "how much weight did you lose?" She replied "75 pounds - no 65 pounds as I have put 10 back on." He asked "where?" She responded to say "right here", and to show him her abdominal fat roll by grabbing it in her two hands.

Patient A testified that he responded by grabbing her roll of fat and by saying, "that's not fat." He then "grabbed my boob" and said, "The fat didn't go there either." Patient A described that she sat there "frozen" and in disbelief as to what just happened. Patient A testified that Dr. Schwarz then told her to stand up and he put both of his arms around her from the front and placed his hands on her "butt," rubbed the area and said, "the fat didn't go there either." Patient A described Dr. Schwarz's hands as making cupped, circular motions while on her buttocks and his hand to be making a soft rubbing motion while on her breast. Patient A testified that then, she stepped back away from Dr. Schwarz and he cupped her left breast again. Patient A said she stepped away again and he said "come here little one" and hugged her and said, "again, don't talk like that in the hallway." Patient A testified she sat down again briefly and then to end the visit, the patient opened

the door to the examining room and said, “Well, this has been an interesting visit.” She then left the office.

Patient A was hospitalized on October 24th for an episode of vomiting and abdominal pain and subsequently returned to see Dr. Schwarz on December 4th, ostensibly to obtain a repeat prescription for a cream she used for eczema, and also to question him about what he had done.

Patient A testified that her real intention was to confront Dr. Schwarz with his behavior and have her questions answered. Patient A testified that Dr. Schwarz responded to all her questions. Among other things, Patient A said Dr. Schwarz told her “I turned him on…it doesn’t matter that we’re married…when two people like each other, nothing like that matters.” Patient A testified that she told Dr. Schwarz she was not interested in “sexual activities,” and then as she went to leave Dr. Schwarz “grabs my butt.” She felt he had not listened to her and she could not believe what had just happened.

Patient A subsequently reported these incidents to a doctor at the local hospital and she also reported the matter to the police.

On the basis of its assessment of the witnesses’ credibility and the consideration of the evidence as a whole, the Committee accepted Patient A’s version of the events and concluded that Dr. Schwarz engaged in sexual abuse of Patient A by touching of a sexual nature, that is, by touching of her breasts and buttocks during office visits on October 16th and December 4th, 2015 in a manner that was not clinically indicated or appropriate.

The Committee also found that comments made by Dr. Schwarz to Patient A, such as his responses to her questions on December 4, 2015 that she turned him on and that it did not matter that they were both married, were clearly inappropriate and sexualized, and that this constitutes sexual abuse of a patient by remarks of sexual nature.

Sexual abuse of a patient violates a patient’s trust, autonomy and dignity. Such conduct towards a patient constitutes disgraceful, dishonourable or unprofessional conduct.

Disgraceful, Dishonourable or Unprofessional Conduct regarding Nurse A, Nurse B and Nurse C by Behavior and Remarks of a Sexual Nature

Dr. Schwarz is a family physician practising in City 1, Ontario. Dr. Schwarz held privileges at a Hospital between 2003 and 2015.

The Committee found that Dr. Schwarz committed an act of professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, regarding Nurse A, Nurse B and Nurse C.

Nurse A
Nurse A worked at the Hospital. During a night shift circa 2012, at approximately 11:30 p.m., Dr. Schwarz and Nurse A were standing alone near the nursing station. Dr. Schwarz hooked his finger into the rim of Nurse A's scrub pants, and pulled them down no more than two inches to view her lower back tattoo. He said, "What's that." Nurse A said "Whoa" and pulled away. In an effort to diffuse the situation without making it awkward, Nurse A then lifted her shirt slightly to allow Dr. Schwarz to see the tattoo, said "It's my tattoo," and left the room.

The incident made Nurse A highly uncomfortable. Afterwards, she no longer wanted to work the night shift with Dr. Schwarz, and arranged her schedule accordingly. She did not want to be alone in the department with him, especially at night. She subsequently reported the incident to the department's Chief of Staff. After the event, Dr. Schwarz had no further incidents involving Nurse A.

Nurse B
Nurse B began working at the Hospital. During one early afternoon shift in the Hospital, circa 2010, Nurse B received lab results for a patient which required a physician's review. Nurse B went into the doctor's lounge to provide Dr. Schwarz with the lab results. Nurse B and Dr. Schwarz reviewed the results together. As they were exiting the doctor's lounge, Dr. Schwarz slapped Nurse B on the buttocks. Nurse B turned around and said, "Don't touch me like that."

After this incident, Nurse B felt uncomfortable around Dr. Schwarz. She would no longer go to the doctor's lounge in person to provide test results as she did not want to be subjected to this conduct again. She subsequently reported the incident to the department's Chief of Staff.

Sometime after this incident, Dr. Schwarz approached Nurse B while she was seated at a computer and squeezed her shoulders in a massage-like fashion. Nurse B gave Dr. Schwarz a "dirty look," after which he departed. After the events, Dr. Schwarz had no further incidents involving Nurse B.

Nurse C
Nurse C began working in the Hospital. During one day shift, Nurse C entered the medication room to retrieve an item. The medication room is small: approximately six feet by seven feet. Dr. Schwarz followed Nurse C into the room and stood in the doorway, approximately four feet away from Nurse C. When Nurse C reached up to take down some medication, Dr. Schwarz said, "you have a lower back tattoo, that's so sexy, can I see it." Nurse C said "no." She felt very uncomfortable, because she had no way out of the room. Dr. Schwarz laughed and walked away.

During another shift, after the first incident, Nurse C and Dr. Schwarz were alone in the Department. Nurse C was seated at a computer. Dr. Schwarz approached her from behind

and began to massage her neck and shoulders. Nurse C stopped what she was doing and tensed up. She felt extremely uncomfortable. Dr. Schwarz continued the massage for approximately one minute before walking away.

On another occasion around the same time period, Dr. Schwarz made an inappropriate sexual comment to Nurse C. Nurse C felt uncomfortable and shut down the conversation. As a result of these encounters, Nurse C tried to avoid Dr. Schwarz as much as she could while continuing to do her job. After the events described above, Dr. Schwarz had no further incidents involving Nurse C.

Given the Committee's findings of touching of a sexual nature of the patient's breasts and buttocks, the Committee made an immediate interim order suspending Dr. Schwarz's certificate of registration, until such time as the Committee makes an order under subsection 5 or 5.2 of the Code.

The Penalty hearing was held on September 10 and 11, 2019. The Committee reserved its decision. On December 2, 2019, the Committee issued its decision on penalty.

Disposition

On December 2, 2019, the Committee ordered that:

- The Registrar revoke Dr. Schwarz's certificate of registration, effective immediately;
- Dr. Schwarz reimburse the College for funding provided to the patient under the program required by s. 85.7 of the Code, in the amount of $16,060, and to post an irrevocable letter of credit or other security acceptable to the College, in that amount, to guarantee payment of any amounts he may be required to reimburse;
- Dr. Schwarz appear before the Committee to be reprimanded within 60 days of the date of this Order;
- Dr. Schwarz pay costs to the College in the amount of $82,960.00, within 90 days of the date of this Order.

Appeal

On December 30, 2019, Dr. Schwartz appealed the Discipline Committee's March 8, 2019 decision on finding and December 2, 2019 decision on penalty to the Divisional Court.

Failed to Maintain the Standard of Practice of the Profession – 2 cases

1. Dr. W. Ateyah

Name:	Dr. Wameed Ateyah
Practice:	Family Physician
Practice Location:	Beeton
Hearing:	Contested Allegations and Penalty
Finding Decision Date:	July 19, 2019
Penalty Decision Date:	December 23, 2019
Written Decision Date:	December 23, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **unproven**
- sexual abuse of a patient -**unproven**
- incompetence - **withdrawn**

Summary

On July 19, 2019, the Discipline Committee found that Dr. Wameed Ateyah committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession.

On a morning of a date in October 2016, Patient A attended Dr. Ateyah's office as a walk-in patient. She complained of back pain and some vaginal itchiness. Dr. Ateyah examined Patient A.

The Committee found that Dr. Ateyah did not clearly communicate to Patient A in advance the type of examination he intended to perform or the reasons for the examination. In the result, Patient A was confused and did not understand what Dr. Ateyah was doing or why he was doing it during the initial examination on the examination table.

The Committee found that Dr. Ateyah failed to maintain the standard of practice of the profession in not clearly explaining to Patient A the type of examination he intended to conduct before embarking on the examination, and the reasons for conducting that examination.

On October 7, 2019, the Committee heard submissions on penalty. The Committee reserved its penalty decision.

Disposition

On December 23, 2019, the Committee released its penalty decision, and ordered that:

1. The Registrar suspend Dr. Ateyah's certificate of registration for a period of two months, commencing on January 6, 2020 at 12:01 a.m;

2. The Registrar place the following terms, conditions or limitations on Dr. Ateyah's certificate of registration:

(i) Dr. Ateyah shall comply with the College Policy "Closing a Medical Practice", a copy of which is attached to this Order;

(ii) Dr. Ateyah will participate in the Saegis Successful Patient Interactions Course by receiving a passing evaluation or grade, without any conditions or qualification. Dr. Ateyah will complete the Saegis course within 6 months of the date of this Order and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

3. Dr. Ateyah shall appear before the Committee to be reprimanded; and

4. Dr. Ateyah shall pay to the College costs in the amount of $20,550.00 within 60 days of the date of this Order.

2. Dr. M. Hoffer

Name:	Dr. Mayer Hoffer
Practice:	Psychiatry
Practice Location:	Toronto
Hearing:	Uncontested facts and Plea of No Contest on Liability Penalty – Joint Submission
Finding/Penalty Decision Date:	December 2, 2019
Written Decision Date:	January 23, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

On December 2, 2019, on the basis of a Statement of Uncontested Facts, the Discipline Committee found that that Dr. Hoffer committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession. Dr. Hoffer did not contest that based on these facts, he engaged in professional misconduct in that he failed to maintain the standard of practice of the profession in his care of 28 patients.

Dr. Hoffer is a 64-year-old psychiatrist who received his certificate of registration authorizing independent practice from the College in June 1979. At the relevant time, Dr. Hoffer practiced psychiatry in Toronto, Ontario. His practice focused on the treatment of attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) in both children and adults.

Between March 2016 and December 2018, the College received information of concern regarding Dr. Hoffer's clinical practice, including reports from three psychiatrists working at local hospitals regarding Dr. Hoffer's care of their mutual patients, and one complaint from the brother of a patient of Dr. Hoffer's who had recently been hospitalized. The College commenced investigations into Dr. Hoffer's psychiatric practice.

As part of its investigations, the College obtained independent opinions from Dr. Donald Duncan, a child and adolescent psychiatrist with expertise in the assessment and treatment of ADHD across the lifespan and Assistant Clinical Professor of Psychiatry at the University of British Columbia, practicing in British Columbia; Dr. Nicholas Delva, a general adult psychiatrist and former Head of the Department of Psychiatry at Dalhousie University; and Dr. Christopher Bryniak, a psychiatrist with experience in general adult psychiatry, forensic psychiatry and emergency psychiatry. Dr. Delva reviewed Dr Hoffer's care of one patient (Patient A). Dr. Bryniak reviewed Dr. Hoffer's care of one patient (Patient B). Dr. Duncan reviewed Dr. Hoffer's care of 28 patients (including Patient A and Patient B).

Failure to Maintain the Standard of Practice of the Profession

A. Record Keeping

The expert opinions concluded that one or more of the following deficiencies with respect to record keeping and documentation were present in each of the 28 patient charts reviewed:

i. The charts were not legible. They were difficult to read and often disorganized. It was not possible to read all chart entries without first obtaining a transcription;

ii. The rationale behind treatment decisions was often missing, vague or contradictory (for example, despite a notation that the patient was “doing well”, the record indicated that the patient’s medication had been changed or the dosage increased);

iii. Records of medication dosing were often vague (for example, indicating “prescribing Dexedrine” or “Dexedrine 1/1” but failing to record the precise dosage prescribed);

iv. Medication changes were frequently made between recorded patient encounters, with no notation of when these changes were made or why. Although Dr. Hoffer frequently provided care over the telephone, he rarely documented phone-based reviews and treatment changes;

v. In some cases, Dr. Hoffer failed to document discussions regarding informed consent, including a review of medication risks, prior to initiating high doses of stimulants or other drugs, off-label medications, or multiple medications with similar mechanisms of action;

vi. For one patient reviewed by the College experts, the available chart did not document the basis for the diagnosis of ADD (although the expert acknowledged this did not necessarily mean the patient did not have this disorder);

vii. For some patients, Dr. Hoffer failed to document relevant clinical information, such as substance misuse, vitals or family history.

B. Communication with Family/Referring Physician

Dr. Hoffer did not provide any initial or ongoing reports to family physicians or referral sources regarding findings, treatment recommendations, treatment plans or changes in clinical status or treatment plan. The charts reviewed contained no evidence of any communication between Dr. Hoffer and family physicians/referral sources. Dr. Hoffer relied instead on patients to update their family physicians regarding their treatment and prescriptions. The expert opinions concluded that this lack of communication with referral sources and reliance on patients to keep their family physicians informed of their treatment was not reliable, adequate or appropriate.

C. Prescribing

The expert opinions concluded that the following deficiencies with respect to prescribing were present in some of the charts reviewed:

i. Failure to optimize dose before changing prescription

In two cases reviewed by the College experts, Dr. Hoffer added new medications without first optimizing the dose of medications already prescribed or before sufficient time had elapsed to assess the treatment response to currently prescribed medications.

ii. Failure to review ongoing need for medications

In two cases reviewed by the College experts, there was no evidence in the chart that Dr. Hoffer reviewed the need to continue prior medications after a new medication had been introduced and resulted in a positive response. This practice could potentially result in patients being on multiple unnecessary medications.

iii. Failure to meet criteria before prescribing high stimulant doses

For some patients, Dr. Hoffer prescribed stimulant doses well above the maximum doses set out in the product monographs or recommended by the Canadian ADHD Resource Alliance (CADDRA) without meeting necessary conditions, such as:

1. First trialling alternative medications prescribed within the normal dosage range (for example, trialling normal doses of methylphenidate before exceeding the maximum recommended dose of dextroamphetamine, or vice versa);

2. Documenting his discussion about explaining the risks and benefits with the patient and informing patients that the proposed doses are beyond the typically recommended doses;

3. Documenting the outstanding clinical concerns and medication-responsive target symptoms believed to justify the exceptionally high doses;

4. Documenting vital [sign]s regularly.

While prescription of stimulants above the maximum doses recommended by CADDRA or the product monographs may be appropriate for some patients, higher doses involve increased risk to patients and require careful consideration of risks and benefits and fully informed consent.

ii. Use of Stimulants in Psychotic Patients

The expert opinions concluded that Dr. Hoffer failed to maintain the standard of practice in his treatment of patients who exhibited psychosis.

a. Patient A

Patient A was a pre-existing patient who returned to Dr. Hoffer's practice in 2010 after a multi-year absence. Dr. Hoffer's chart for Patient A did not include the visits prior to 2010.

Two experts retained by the College opined that Dr. Hoffer's care of Patient A failed to meet the standard of practice of the profession, demonstrated a lack of judgment and placed this patient at a risk of harm in that:

a. His record keeping was substandard, lacking relevant positive and negative findings at each visit, and failing to document the clinical decisions made and the rationale behind decisions;

b. Despite multiple indications in the records that Patient A had a problem with substance misuse, there was no documentation of whether she might meet the criteria for Substance Use Disorder. Dr. Hoffer failed to diagnose or adequately deal with the misuse of amphetamines in this case;

c. The dose of amphetamines used was excessive (up to three times the recommended maximum of the product monographs and more than double the CADDRA recommended daily maximum), and Dr. Hoffer failed to meet appropriate conditions for providing such a high dose of amphetamines (as set out above);

d. There was no evidence Dr. Hoffer monitored the patient's physiological safety while on these high doses of stimulants, or communicated with the patient's family physician so they could monitor accordingly;

e. His response to evidence of severe medication intolerance, when Patient A was diagnosed with amphetamine-induced psychosis on more than one occasion when she presented to the hospital, was inadequate:
- He minimized the validity of the psychotic episodes;
- He explicitly questioned the possibility that a patient with ADHD can experience stimulant induced psychosis;
- After the patient required three admissions for episodes of psychosis while on amphetamines (a condition which cleared each time shortly after discontinuation of the amphetamine), Dr. Hoffer continued to prescribe stimulants against the advice of two inpatient treatment teams;

b. Patient C

Patient C was referred to Dr. Hoffer by her family physician in 2007 for treatment of ADD diagnosed 10 years previously. Dr. Hoffer confirmed the diagnosis and started her on Dexedrine 32.5 mg in three divided doses. Over three years, the dose was gradually increased to a maximum dose of 60mg daily.

The expert opinion identified the following deficiencies in Dr. Hoffer's care of Patient C (in addition to record keeping and failing to communicate with the family physician):

i. Dr. Hoffer failed to notice or acknowledge collateral reports of paranoia while the patient was on relatively high doses of Dexedrine;

ii. Dr. Hoffer never trialled Patient C on alternate ADHD medications despite her repeated destabilization on Dexedrine;

iii. He increased her dose of Dexedrine, despite documenting that she was "doing much better" – with the sole documented rationale being "only on Dexedrine spansules 10 mg b.i.d.";

iv. In a vulnerable patient, he restarted Dexedrine between documented appointments without making a record.

The College expert opined that Dr. Hoffer's care likely exposed this patient to harm or injury on the basis of repeated use of stimulant medication in psychotic patient who repeatedly decompensates.

c. Patient D

Patient D had a history of ADHD and was referred to Dr. Hoffer by a family physician. He was started on Dexedrine with good effect. Later, he developed psychosis and was diagnosed with schizophrenia.

Dr. Hoffer trialled several medications to treat the patient's psychosis, but the patient stopped them. Dexedrine was then prescribed to treat Patient D's concentration problems.

The expert opinion identified the following deficiencies in this patient's care (in addition to record keeping and failure to communicate with the family physician):

i. Dr. Hoffer used Dexedrine to treat concentration problems in a patient with uncontrolled and untreated schizophrenia, which was likely to expose this patient to harm or injury;

ii. The prescription for Dexedrine included 20mg "at bedtime". There was no record of this prescription or of the clinical rationale for a bedtime stimulant in the clinical notes;

iii. Dr. Hoffer maintained Patient D on weekly Dexedrine dispensing with no detailed record of in-person contact with this schizophrenic patient for over one year (between April 2015 and June 2016);

iv. Medication was dispensed weekly with no explanation for this mode of dispensing in the chart;

v. Dr. Hoffer provided Dexedrine prescriptions above the recommended daily maximum (Dexedrine 60 mg/day) in a psychotic individual who was not being seen regularly for review.

iii. Patient E

Patient E was diagnosed with ADHD and also suffered from comorbid depression, diabetes and hypertension. He was referred to Dr. Hoffer in 2005. After trialling several stimulants (all dextroamphetamine), Dexedrine was chosen as the treatment of choice.

On several occasions between 2007 and 2012, Dr. Hoffer recorded that the patient had unilaterally increased the dose or frequency of his Dexedrine.

Dr. Hoffer continued to prescribe Dexedrine to Patient E for 68 months (between March 21, 2013 and November 20, 2018) without ever seeing the patient in person. During this 68-month period, Dr. Hoffer was subject to an Undertaking with the College which required him to see patients at least once per year, prior to renewing any prescriptions. As such, his prescribing to Patient E during this period was in breach of his undertaking with the College.

In November 2018, Patient E's case worker called 911 after visiting his home and finding him doing poorly and the house in disarray. He was admitted to hospital. Per the hospital documentation, Patient E stated that he had taken too much behaviour/mood medication and ended up sleeping for 3 days. He also reporting having run out of his Dexedrine several days prior to his admission, and sleeping. As a result, he had not managed his insulin injection during the days he was sleeping.

While in hospital, Patient E's Dexedrine prescription was discontinued, as the Consultation Liaison Psychiatry service concluded he did not have ADHD and did not need Dexedrine. When Patient E attempted to use his own supply of Dexedrine (he had 540 tablets with him at admission), the medication was confiscated. This led to an altercation between the patient and security staff.

During hospitalization, the Consultation Liaison Psychiatry service spoke with Dr. Hoffer. It is documented that Dr. Hoffer indicated that he had seen the patient within the last year and that he was not aware that the patient was taking higher doses than were prescribed, or more frequently than prescribed. These statements were not true, and were contradicted by Dr. Hoffer's clinical record.

Upon discharge, it was recommended that Patient E not restart Dexedrine. His supply of Dexedrine was not returned to him. These recommendations, contained in the discharge summary, were copied to Dr. Hoffer.

Dr. Hoffer saw Patient E three days after discharge. His records state:

i. "...ran out of Dexedrine – sleeping for 3 days and got ill; may have been due to the flu"
ii. "Dex ... every 2 hours (recent change) ... 7-9 tabs per day"
iii. "no changes to his medication during hospitalization"
iv. "had recently changed his dosing (schedule which has minimized the "up and down" affective Dexedrine (along with the elimination of "sleep attacks" during the day)"

At the November 20, 2018 visit, Dr. Hoffer restarted Patient E's Dexedrine prescription at 5 mg. t.i.d., giving the patient a prescription for 1 month with 2 refills.
30. The expert opinion identified several concerns in Dr. Hoffer's care of Patient E (in addition to the deficiencies with record-keeping and follow-up reporting outlined above), set out below.

i. Failure to address medication misuse

Although the patient began taking Dexedrine at higher doses and at a higher frequency than prescribed, there was no record of Dr. Hoffer cautioning the patient against this practice. Even after the patient was hospitalized for challenges potentially due in part to excessive use of stimulants, Dr. Hoffer continued to prescribe the Dexedrine without any documented discussion regarding the misuse.

During an interview with the medical assessor, Dr. Hoffer indicated that he would not consider Substance Use Disorder in this patient because there was no history of using medication "to get high". This indicates an error in judgment for two reasons: first, patients do not only misuse medications "to get high"; and second, Dr. Hoffer had in fact documented that patient's history of misusing testosterone in the past and was aware of a history of medication misuse for this patient.

ii. Continued prescription renewals without regular face-to-face visits

Dr. Hoffer should not have continued to prescribe Dexedrine, a controlled substance, for almost 6 years without seeing the patient. This failed to meet the standard of practice in prescribing.

iii. Exposure to harm

Dr. Duncan concluded that Dr. Hoffer's care of Patient E exposed the patient to serious risk of harm. Although Dr. Hoffer was not directly responsible for the patient taking more medication than prescribed, he was indirectly responsible by failing to address the patient's ongoing pattern of medication misuse and by continuing to prescribe the medication without seeing the patient for almost 6 years.

FACTS ON PENALTY

On November 27, 2019, Dr. Hoffer entered into an undertaking with the College, whereby he agreed to resign his certificate of registration and never apply or reapply for registration as a physician in Ontario or any other jurisdiction as of December 1, 2019.

Discipline History with the College

In 2008, the Discipline Committee of the College found Dr. Hoffer to have engaged in professional misconduct, in that he failed to maintain the standard of practice of the profession. Dr. Hoffer failed to assess Patient AA [identified as Patient A in the Discipline Committee's 2008 decision and reasons] in person between 2002 and 2004, which constituted a failure to maintain the standard of practice of the profession. Dr. Hoffer also failed to maintain the standard of practice of the profession in record-keeping for Patient AA (including the absence of clinical notes and inadequate medication records from October 2000 to September 2004) and Patient BB [identified as Patient B in the Discipline Committee's 2008 decision and reasons] (specifically, deficiencies in documentation of the medications prescribed, changes in dosage, reasons for medication and dosage changes and follow-up plans). Dr. Hoffer was ordered to complete a medical record-keeping course, a prescribing course, and to undergo clinical monitoring and a re-assessment of his practice. He was also reprimanded and ordered to pay costs. Dr. Hoffer complied with the terms of the Order.

<u>Past Inquiries, Complaints and Reports Committee Decisions</u>

In May 2007, the College's Complaints Committee issued a written caution to Dr. Hoffer.

In August 2010, the ICRC agreed to accept an undertaking from Dr. Hoffer following its consideration of the results of a s. 75(a) investigation and a reassessment conducted pursuant to the Order of the Discipline Committee.

In June 2015, the College's Inquiries, Complaints and Reports Committee ("ICRC") issued a caution in person to Dr. Hoffer.

Disposition

On December 2, 2019, the Discipline Committee ordered that:

- Dr. Hoffer attend before the panel to be reprimanded.
- Dr. Hoffer pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

Found Guilty of Offence Relevant to Suitability to Practise – 1 case

1. Dr. H. Wu

Name:	Dr. Howard Wu
Practice:	Family Medicine
Practice Location:	Markham
Hearing:	Agreed and Uncontested Statement of Facts Contested Penalty
Finding/Penalty Decision Date:	October 17, 2019
Written Decision Date:	January 8, 2020

Allegations and Findings

- found guilty of offence relevant to suitability to practise - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetent proven

Summary

Dr. Wu is a 50 year-old family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario in June 1997. He completed his medical degree at Queen's University in 1994, and his postgraduate training in family medicine through the University of Toronto in 1997. At the relevant time, Dr. Wu practised family medicine in Markham, Ontario at the Smart Health Medical Clinic.

Registrar's Investigation re Death of Patient A

On June 3, 2016, the College received a letter from the Chief Coroner for Ontario describing concerns about the care and treatment that Dr. Wu provided to Patient A in November and December 2015, specifically regarding Dr. Wu's approach to medical assessment and care of a febrile neonate (a newborn with a fever). Patient A died on December 3, 2015 in hospital of E.coli sepsis due to meningitis. He was 19 days old.

The College appointed investigators on June 23, 2016. A physician was retained as a medical inspector to provide an independent opinion regarding Dr. Wu's care of Patient A. The medical inspector interviewed Dr. Wu, and reviewed Dr. Wu's office chart as well as hospital and ER records.

In his report, dated September 28, 2016, the medical inspector opined that the care Dr. Wu provided to Patient A did not meet the standard of practice of the profession and displayed a lack of knowledge, skill, and judgment. The medical inspector was concerned regarding Dr. Wu's chart note that he recommended the patient, a newborn, be given water and vitamin C-rich juice when he saw him on November 25, 2015. The

infant's elevated temperature reported in the subjective notes on that date was concerning and Dr. Wu should have recommended the mother bring her son to hospital immediately. On a subsequent visit two days later, the temperature was still elevated at 37.4°C and the inappropriate recommendation to add water was repeated in the chart. Dr. Wu also used an infrared thermometer to measure body temperature in the context of evaluating a potentially critical illness, which is not recommended. The medical inspector further opined that Dr. Wu's clinical practice, behaviour or conduct exposed or was likely to expose newborn patients to harm or injury.

Dr. Wu failed to maintain the standard of practice of the profession and was incompetent in respect of his care and treatment of Patient A.

Registrar's Investigation re Medical Devices

Sun Life Assurance Company of Canada ("Sun Life") wrote to the College expressing concern regarding Dr. Wu's completion of medical supply claims. Sun Life had received a "very high quantity of medical supply claims bearing referrals" from Dr. Wu, and, because it suspected there was no medical necessity underlying the claims, Sun Life had requested medical notes from the patients. Upon review, as noted by a Sun Life medical consultant, the clinical notes were all in the same format and cited similar complaints, stated that investigation had been refused by the patient, and contained identical treatment plans. There was no medical support for prescription of the devices. Sun Life also noted connections between Dr. Wu and the medical supplier, Health A. Smart Wellness Centre (also known as 'Health Aid'), namely that Dr. Wu's administrator was a director of the wellness centre.

College investigators were appointed as a result, and another physician was retained as the second medical inspector. She reviewed patient charts from Dr. Wu's office and corresponding information from Sun Life, and interviewed Dr. Wu.

Dr. Wu does not admit but does not contest that, as he stated in his interview with the second medical inspector, he received financial compensation in respect of the patients to whom he prescribed the medical devices from the wellness centre that supplied the devices:

- the proprietor of the wellness centre had access to Dr. Wu's computer system;
- the wellness centre would schedule patients for Dr. Wu to see;
- he prescribed those patients braces and other medical devices;
- this took place between 2011 and 2015;
- he was paid $100 per patient per year for every patient to whom he prescribed medical devices and referred to the wellness centre next door.

As the second medical inspector found, Dr. Wu failed to maintain the standard of practice of the profession in his care and treatment of nineteen patients (i.e. all of the patient charts reviewed by the second medical inspector) presenting with

musculoskeletal complaints who were referred to him from the wellness centre next door, for example in the use of multiple bracing at a single visit or over several visits in a short period of time, lack of investigations, and lack of follow-up. While the second medical inspector did not find that Dr. Wu's behaviour or conduct exposed the nineteen patients whose care she reviewed to harm or injury, she did find that his care displayed a lack of knowledge, skill and judgment.

The College investigator sought more information and documentation from Dr. Wu regarding his financial relationship with the wellness centre. However, Dr. Wu advised that he was unable to provide the information requested, by letter dated April 12, 2018.

In a prior investigation in 2013-2014, Dr. Wu provided responses to the College asserting that he had no financial interest in the sale of braces/medical devices which were sold by the same wellness centre next to his clinic, and that there was no conflict of interest in relation to Dr. Wu's prescription of braces and the payment for these devices to the wellness centre. Dr. Wu does not admit but does not contest that the information Dr. Wu provided to the College at that time was untrue. Dr. Wu's assertions to the College are contained in prior correspondence dated October 8, 2013, October 24, 2013, November 25, 2013, and January 15, 2014.

Dr. Wu admitted that he failed to maintain the standard of practice of the profession with respect to the nineteen patients whose care was reviewed by the second medical inspector. Dr. Wu does not contest that he had a conflict of interest and engaged in disgraceful, dishonourable or unprofessional conduct with respect to his financial relationship with the medical devices supplier. Dr. Wu does not contest that he also engaged in disgraceful, dishonourable or unprofessional conduct in failing to disclose this financial relationship to the College in a prior investigation and in providing untruthful information regarding to the College about it.

Registrar's Investigation regarding Eye Examinations

On April 2, 2015, the College received information from an investigator at Sun Life raising concern regarding claims submitted for eye examinations by Dr. Wu. Sun Life had received approximately eight hundred eye examination claims for services rendered by Dr. Wu between January 3, 2012 and March 20, 2015. To determine whether eye examinations were within Dr. Wu's scope of practice, Sun Life had sought to contact Dr. Wu on four occasions, but he had failed to respond. Dr. Wu apologized for failing to respond to the email from Sun Life in a letter to the College investigator on June 7, 2018.

The College initiated an investigation. It faced challenges in obtaining Dr. Wu's patient records for review during the course of its investigation. The College began to seek the records in the summer of 2015. Dr. Wu advised in November 2015 that none of the twenty-five individuals whose records were sought (based on claims having been

submitted to Sun Life for eye examinations he conducted) were “patients of his clinic,” but instead were “customers of Fuji Optical Company.” Between November 2015 and September 2016, the College attempted to retrieve Dr. Wu’s medical records in respect of these patients from Fuji Optical, eventually being provided with eight two-page patient charts in September 2016. Dr. Wu advised he had no document, file, record, or other material in relation to any of the listed individuals.

The College retained a third medical inspector to provide an independent opinion regarding Dr. Wu’s care and treatment of patients based on seven patient charts that were able to be retrieved from Fuji Optical as well as fifteen other patient records regarding eye care obtained from Dr. Wu’s office in 2017. The third medical inspector also interviewed Dr. Wu.

The third medical inspector’s report was received on April 4, 2017 and addendum received on April 11, 2017. As the third medical inspector concluded, Dr. Wu did not meet the standard of practice of the profession in the care and treatment of the twenty-two patients whose charts were reviewed. The refractions he performed were incomplete with key elements not being performed. Major elements of the exam were missing in periodic oculo-visual assessments. Dr. Wu lacked both knowledge and judgment, for example having trouble in the interview describing basic instruments used for refraction or articulating the basic steps refracting a patient. Dr. Wu had advised the third medical inspector in his interview that he was no longer performing refractions or complete eye examinations. The third medical inspector opined that if Dr. Wu were to continue to perform refractions or complete eye examinations, there would be significant risks to patients, with risk to children and older patients in particular.

As the third medical inspector observed in his report, Dr. Wu submitted claims to the Ontario Health Insurance Plan for periodic oculo-visual examinations performed in his office, without performing minimum elements required by the Schedule of Benefits.

Dr. Wu provided a response to the third medical inspector’s report. Upon reviewing it, the third medical inspector provided the College with a further report containing his reply, dated November 12, 2017. The third medical inspector remained concerned that Dr. Wu had gaps in his knowledge of the basic technique of refracting and had trouble identifying basic equipment. Some charts did not identify pre-op vision and none identified post-op vision. Nor was the third medical inspector confident that Dr. Wu was in a position to identify issues that required directing the patient to a doctor for a proper examination. There continued to be concerns regarding Dr. Wu’s in-office examinations and the specific charts reviewed.

Dr. Wu admitted that he failed to maintain the standard of practice of the profession in his care and treatment of the twenty-two patients whose charts were reviewed by the third medical inspector and that he was incompetent in respect of his care and treatment of these patients. Dr. Wu admitted that he engaged in disgraceful,

dishonourable or unprofessional conduct in respect of his failure to respond to Sun Life's inquiries, in submitting claims to OHIP that were not appropriately supported by his records and failing to ensure appropriate storage and maintenance of his medical records.

Reassessment of Family Practice

On March 8, 2016, Dr. Wu entered into an undertaking which required him to complete professional education, including clinical supervision, and to undergo a reassessment. Dr. Wu had entered into the 2016 Undertaking as a result of a prior unsatisfactory reassessment of his family practice, performed in March 2015 by a physician assessor, who had found that Dr. Wu had failed to maintain the standard of practice of the profession and showed a lack of judgment in his care of four patients and in maintaining proper hygiene.

As required by the 2016 Undertaking, Dr. Wu completed a medical record-keeping course offered by the University of Toronto and completed summaries regarding his review of a number of policies, guidelines, and clinical issues. Dr. Wu also completed a period of supervision from March 2016 to July 2017.

A second physician assessor was retained by the College to reassess Dr. Wu's practice under the terms of his 2016 Undertaking. The second assessor reviewed twenty of Dr. Wu's patient charts, observed Dr. Wu's encounters with six patients on November 29, 2018, performed an infection control office inspection, and interviewed Dr. Wu. The second assessor's reassessment report was received January 8, 2019 and his addendum report received January 21, 2019. As the second assessor found, Dr. Wu failed to maintain the standard of practice of the profession and displayed a lack of judgment in his care of three patients, placing them at risk of harm.

Dr. Wu admitted that he failed to maintain the standard of practice of the profession in his care and treatment of the three patients identified by the second assessor. Dr. Wu admitted that he was incompetent in his care and treatment of one patient whose care was reviewed by the second assessor in what he identified in his report as Chart #1. In that case, Dr. Wu failed to conduct a pertinent history and investigation in managing a patient with suspected angina.

Registrar's Investigation regarding Offences

On August 24, 2017, the College received an anonymous letter alleging that Dr. Wu "was suspended from driving and again recently for Criminal Code violation," and that the information was not contained on the College's public Register, which should be remedied.

The College initiated an investigation. It obtained Dr. Wu's criminal record and driver's

licence history from the Ontario Provincial Police ("OPP") on August 31, 2017. As they indicate, on September 10, 2015 Dr. Wu was convicted of dangerous driving under the *Criminal Code*, and on January 9, 2017, Dr. Wu was convicted of driving while disqualified under the Criminal Code.

Additional information obtained from the OPP on January 4, 2018, demonstrates that on August 4, 2014, Dr. Wu was arrested on Highway 407 by the OPP and charged under the *Criminal Code* with dangerous operation of a motor vehicle, flight while pursued by a police officer, and assault with intent to resist arrest, as well as offences under the *Compulsory Automobile Insurance Act* and the *Highway Traffic Act*.

As a member of the College, Dr. Wu was required to complete an annual renewal report. On May 20, 2015, Dr. Wu completed his Annual Renewal Report to the College. In it, he answered "no" to the question, "Since April 1, 2014, have you been charged with any offence in Canada or elsewhere?" This was untrue.

On September 10, 2015, Dr. Wu attended court in Newmarket, Ontario, where he pleaded guilty to the charge of dangerous operation of a motor vehicle under the *Criminal Code* (s. 249(1(a)) and received an absolute discharge for the dangerous driving charge. He was prohibited from driving for one year under the *Criminal Code*. He also pleaded guilty to operating a motor vehicle without insurance under the *Compulsory Automobile Insurance Act* (s. 2(1)(a)) and was fined.

Nonetheless, on May 20, 2016, Dr. Wu answered 'no' to the following question on his Annual Renewal Report to the College: "Since April 1, 2015, have you been charged with and/or found guilty of, any offence in Canada or elsewhere? (Include all offences under the *Criminal Code of Canada*, the *Controlled Drugs and Substances Act*, the *Food and Drugs Act*, the *Health Insurance Act*, and/or related legislation in any Province or jurisdiction. In addition, include any other offences related to the practice of medicine."). Dr. Wu's response was untrue.

On September 5, 2016, Dr. Wu was arrested by the York Regional Police and charged with driving while disqualified under the *Criminal Code* and operating a motor vehicle without insurance under the *Compulsory Automobile Insurance Act*. On January 9, 2017, Dr. Wu pleaded guilty to driving while disqualified under the *Criminal Code*, receiving a fine and a prohibition from driving for one year.

Nonetheless, on May 15, 2017, Dr. Wu answered 'no' to the following question on his Annual Renewal Report to the College: "Since April 1, 2016, have you been charged with, and/or found guilty of, any offence in Canada or elsewhere? (Include all offences under the *Criminal Code of Canada*, the *Controlled Drugs and Substances Act*, the *Food and Drugs Act*, the *Health Insurance Act*, and/or related legislation in any province or jurisdiction. In addition, include any other offences related to the practice of medicine.)." On October 18, 2017, after having been contacted by the College investigator in August

regarding this matter, Dr. Wu emailed the College's "Membership" email address, stating, "I am writing to correct one of the mistake [*sic*] I might have made on the renewal of membership last time. I was convicted criminally because [*sic*] driving disqualify. Please correct the mistake I might have made filling out the questionnaire."

Dr. Wu admitted that he engaged in disgraceful, dishonourable, or unprofessional conduct with respect to his failure to disclose to the College, as required, the information relating to have been charged with and found guilty of offences. Dr. Wu admits that he has also been found guilty of offences relevant to his suitability to practice.

Disposition

On October 17, 2019, the Discipline Committee ordered that:
- Dr. Wu attend before the panel to be reprimanded
- the Registrar revoke Dr. Wu's certificate of registration, effective immediately
- Dr. Wu to pay costs to the College in the amount of $31,110.00 within thirty (30) days of the date of its Order.

Disgraceful, Dishonourable or Unprofessional Conduct –
4 Cases

1. Dr. B. C. Bailey

Name:	Dr. Brian Clare Bailey
Practice:	General Practice
Practice Location:	Ottawa
Hearing:	Contested Allegations and Penalty
Finding Decision Date:	May 6, 2019
Written Finding Decision:	May 6, 2019
Penalty/Costs Decision Date:	February 3, 2020
Written Decision Penalty:	February 3, 2020

Allegations and Findings
- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary
On May 6, 2019, the Discipline Committee that Dr. Bailey committed an act of professional misconduct in that he engaged in acts or omissions relevant to the practice of medicine that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Bailey is a 76-year-old general practitioner who received his certificate of registration for independent practice in 1969. Dr. Bailey's practice is located in Ottawa and consists of group psychotherapy, some individual psychotherapy and acupuncture. He is a short-

term mental health provider and selects patients referred to him to attend his "AcuDestress Program".

Dr. Bailey was brought to the attention of the Inquiries, Complaints and Reports Committee ("ICRC") by the College's Quality Assurance Committee in 2015. The ICRC determined after investigation and review that there were aspects of Dr. Bailey's practice that were either unacceptable or deficient and that failed to maintain the standard of practice. Further, the ICRC was of the view that Dr. Bailey was remediable in these areas. On May 4, 2016, the ICRC ordered that Dr. Bailey undergo a specified continuing education or remediation program (a "SCERP") to address the ICR Committee's concerns and to protect the public interest. The May 4, 2016 SCERP included the following components:

- Dr. Bailey shall attend and successfully complete the following four courses: the Medical Record Keeping Course offered through the University of Toronto; the Canadian Medical Protective Association's ("CMPA") e-modules on medical record keeping; the Understanding Boundaries Course, offered through the Schulich School of Medicine, at University of Western Ontario; and the CMPA module on Privacy and Confidentiality.
- Dr. Bailey shall review and provide a written summary (including how they are applicable to his situation as well as how he plans to change his practice) of the following documents: the College's policies on *Complementary Alternative Medicine*, *Telemedicine*, *Consent to Treatment*, *Confidentiality of Personal Health Information*, *Maintaining Appropriate Boundaries and Preventing Sexual Abuse,* and *Medical Records*; and the Ontario Regulation 144/94 or the "Advertising regulation," and the CMPA Good Practice Guide, section on "e-communication";
- Dr. Bailey shall engage in focused educational sessions, in person, with a clinical supervisor acceptable to the College (the Clinical Supervisor); and
- Dr. Bailey shall undergo a reassessment, with an assessor selected by the College approximately six months following completion of the educational plan.

The allegation of professional misconduct in this matter arises from Dr. Bailey's response or lack thereof to the May 4, 2016 SCERP.

The Committee found that Dr. Bailey failed to comply with the May 4, 2016 SCERP as required by the ICRC, including that he failed to comply with the schedule set out for completion of the courses, he failed to secure a clinical supervisor in a timely manner, and he unreasonably delayed the completion of all of its elements. The Committee also found that Dr. Bailey's failure to communicate either in person or through his counsel were an attempt to thwart or delay the process. Such behavior by members of the profession in the view of the Committee is not tolerable.

The Committee noted that panels of the Discipline Committee have made findings of disgraceful, dishonourable or unprofessional conduct in prior cases based on a failure

to comply with or breach of orders of College Committees, including the failure to adhere to a SCERP.

It is clear from Dr. Bailey's testimony that he believed that the SCERP was unfair. His manner of dealing with the situation was to agree to undertake the required remediation, but to thwart the schedule for its completion. Dr. Bailey understood his obligation to comply with the May 4, 2016 SCERP. He delayed complying with the SCERP after his return to practice and to date, has completed it only in part. He failed to communicate in a professional manner with the College staff assigned to his case, despite their repeated efforts to keep the matter moving forward. Dr. Bailey's actions in securing a supervisor were unhelpful and obstructive. There is no acceptable excuse for this behavior.

The Committee found that Dr. Bailey engaged in disgraceful, dishonourable, or unprofessional conduct as alleged.

Disposition

On February 3, 2020, the Discipline Committee ordered that:

- Dr. Bailey shall appear before the Committee to be reprimanded and the fact of the reprimand shall be recorded on the Register;
-
- The Registrar to suspend Dr. Bailey's certificate of registration commencing 14 days following the date of release of this order until the later of:
-
    - Four months after the date the suspension commences; or
    - The date Dr. Bailey provides to the College proof of his successful completion of the PROBE Ethics and Boundaries course.
-
- The Registrar to impose the following terms, conditions and limitations on Dr. Bailey's certificate of registration:
-
    - Dr. Bailey shall comply with all outstanding requirements of the SCERP as set forth in the Decision and Reasons of the ICRC, dated May 4, 2016. The reference to "a boundaries course" will mean the PROBE Ethics and Boundaries Course (rather than the Understanding Boundaries course which Dr. Bailey previously attended).
-
    - Dr. Bailey shall comply with the College Policy "Closing a Medical Practice".
-
- Dr. Bailey pay to the College costs in the amount of $31,110.00, in equal quarterly payments over the course of two years, to commence within 30 days from the date of release of this order and to be completed within 24 months.

2. Dr. S.A. Fikry

Name:	Dr. Sameh Adly Fikry
Practice:	Family Physician
Practice Location:	Kitchener-Waterloo
Hearing:	Uncontested Facts Joint Penalty
Finding/Penalty Decision Date:	November 11, 2019
Written Decision Date:	December 23, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

On November 11, 2019, on the basis of uncontested facts and a plea of no contest, the Discipline Committee found that Dr. Sameh Adly Fikry ("Dr. Fikry") committed an act of professional misconduct in that: he engaged in professional misconduct by engaging in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Fikry is a family physician who received his certificate of registration in 2010. Throughout the relevant time period, Dr. Fikry practised in the Kitchener-Waterloo area. Dr. Fikry has no prior discipline history.

Patient A became a patient in Dr. Fikry's family medicine practice in 2015. She was seen by Dr. Fikry on three occasions in 2015. The first occasion was for a routine "meet 'n' greet". The second occasion was for a complete physical examination. The third occasion, ten days later, related to Patient A's respiratory difficulties.

At the third appointment, Patient A attended at Dr. Fikry's office with complaints associated with asthma exacerbation. Patient A reported having been seen in the Emergency Department for treatment of her asthma six days prior, but her symptoms persisted. She also advised Dr. Fikry that she had called his office the previous Friday afternoon before going to the Emergency Department, but it was closed. Dr. Fikry asked Patient A to enter his cellphone number into her phone for Patient A to use in the event of a future emergency, noting that he occasionally saw patients after hours. Patient A did so.

Dr. Fikry then took an appropriate medical history, Patient A's shirt was lifted, and Dr. Fikry conducted a lung examination. Patient A was wearing a bra. At the end of the examination, Patient A's shirt was put back down. Dr. Fikry prescribed a new medication to treat Patient A's symptoms.

At the end of the clinical encounter as Patient A was leaving Dr. Fikry's examination room, Dr. Fikry said to the patient: "I have something to tell you, but please don't slap my face for it. Your bra, it is very elegant." Dr. Fikry made no other comments to Patient A, and she left his office.

These comments caused Patient A great deal of distress. She did not wish to return to see Dr. Fikry and de-enrolled herself as his patient.

Disposition

On November 11, 2019, the Discipline Committee ordered that:

- The Registrar suspend Dr. Fikry's certificate of registration for a period of two (2) months, to commence on November 19, 2019, at 12:01 a.m.;
- Dr. Fikry attend before the Committee to be reprimanded; and
- Dr. Fikry pay costs to the College in the amount of $10,370.00 within thirty (30) days of the date of the Order.

3. Dr. Md Ashiqul Islam

Name:	Dr. Md Ashiqul Islam
Practice:	Internal Medicine
Practice Location:	Bowmanville
Hearing:	Contested Allegations
Finding Decision Date:	February 4, 2020
Written Decision Date:	February 4, 2020
Penalty Decision Date:	[penalty hearing to be scheduled]

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse of a patient -**unproven**

Summary

The College alleged that Dr. Islam engaged in sexual abuse of and/or disgraceful, dishonourable or unprofessional conduct towards Patient A, during a September 2017 echocardiogram appointment, including by:

- hugging and/or kissing Patient A, including while she was partially clad;
- making remarks of a sexual and/or inappropriate nature to Patient A;

- touching, moving, and/or lifting an item of Patient A's clothing without clinical indication and/or consent; and
- touching Patient A's breasts without clinical indication and/or consent.

The College also alleged that Dr Islam engaged in disgraceful, dishonourable or unprofessional conduct in that he sent an inaccurate consultation letter regarding Patient A to a colleague.

In September 2019, the Discipline Committee heard submissions and testimony from the parties and witnesses, and reserved its decision. On February 4, 2020, the Discipline Committee found that Dr. Islam engaged in an act of professional misconduct, in that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee found that the allegation of sexual abuse is not proven.

With respect to an allegation of hugging, the Committee concluded that Dr. Islam hugged Patient A but found the two hugs did not constitute touching of a sexual nature, but did constitute disgraceful, dishonourable or unprofessional conduct.

3. Dr. P.M.J. Malette

Name:	Dr. Paul Maurice Joseph Malette
Practice:	Family Medicine
Practice Location:	Val Caron
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	November 29, 2019
Written Decision Date:	January 17, 2020

Allegations and Findings

- sex abuse - withdrawn
- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

On November 29, 2019, on the basis of an Agreed Statement of Facts and Admission (Liability), the Discipline Committee found that Dr. Malette committed an act of professional misconduct in that he engaged in acts or omissions relevant to the practice of medicine that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Malette is a 63-year-old family physician practicing in Val Caron, Ontario. He obtained his certificate of registration authorizing independent practice from the College in 1985. Dr. Malette was Patient A's family physician for many years. During the time she was his patient, Patient A suffered from a number of health challenges.

In approximately 2005, Dr. Malette began hugging Patient A at the end of every appointment. These hugs occurred in Dr. Malette's examination room. During some hugs, Dr. Malette's cheek and/or lips made contact with Patient A's cheek, giving Patient A the impression that he was trying to kiss her. Unbeknownst to Dr. Malette, the hugs were unwelcomed by Patient A, and they made her feel extremely uncomfortable.

In September 2008, the College revised its policy on Maintaining Appropriate Boundaries and Preventing Sexual Abuse to include the guideline that physicians should avoid physical contact with patients except where required to perform medically necessary examinations. Dr. Malette's routine hugging of Patient A was not in compliance with the College's policy from September 2008 onwards.

Patient A's medical records indicate that in 2009, Patient A complained to Dr. Malette of loss of libido and loss of sensation in her genital area. She subsequently returned to Dr. Malette with a complaint of numbness in the genitals inhibiting sexual functioning. Dr. Malette examined Patient A's genitals. His examination included a bimanual examination, a Pap test, and palpation of Patient A's vulva and clitoris. While he was palpating her genitals, Dr. Malette asked Patient A to compare the loss of sensation she was experiencing during his examination with the loss of sensation she experienced during sexual intercourse with her husband. Patient A was upset by his question. Dr. Malette did not adequately explain the examination and the purpose of his question to Patient A prior to the examination. The inadequate explanation caused Patient A to be alarmed. Dr. Malette hugged Patient A at the end of this appointment.

Though Patient A remained Dr. Malette's patient for several years, she did not return to him for another pelvic examination. Her next Pap test was not until six years later, with a female registered practical nurse.

The College retained Dr. Carolyn Borins, a family physician, to opine as to whether Dr. Malette's behaviour and remarks were of a clinical nature appropriate to the service provided. Dr. Borins opined that it is inappropriate of physicians to routinely initiate hugs of patients. Such hugs constitute an inappropriate boundary crossing, as there is a power differential inherent in the physician patient relationship. Hugs can be interpreted by patients in different ways, and even if a hug is well-intentioned, physicians cannot predict how the patient will interpret the hug. While showing comfort to patients is important, physicians can demonstrate caring and empathy in other ways to ensure no boundaries are crossed. Dr. Borins further opined that it is inappropriate to ask a patient to compare clinical touching to touching of a sexual nature by a romantic partner. Touching of a clinical nature is distinct from sexual touching, and the two are not comparable. Asking

for such a comparison risks giving the patient the impression that the physician's touch is of a sexual nature.

Disposition

On November 29, 2019, in addition to its finding set out in paragraph 1 of its Order, the Discipline Committee ordered:

1. Dr. Malette attend before the panel to be reprimanded.
2. The Registrar to suspend Dr. Malette's certificate of registration for a period of three (3) months, commencing on December 16, 2019 at 12:01 a.m.
3. The Registrar to place the following terms, conditions and limitations on Dr. Malette's certificate of registration:
    a) Dr. Malette shall comply with the College Policy "Closing a Medical Practice."
    b) Dr. Malette shall participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Malette will complete the PROBE program within six (6) months of the date of the Order, and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.
    c) Dr. Malette shall not conduct any pelvic, genital and/or rectal examination of any patient, of any age, in any jurisdiction, unless the examination takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College under paragraphs 4(d) and 4(e) below.
    d) In respect of his office-based practice (City of Lakes Family Health Team – Val Caron Clinic), Dr. Malette shall retain a Practice Monitor acceptable to the College who has executed the Practice Monitor's undertaking in the form attached to the Order as Appendix "A".
    e) In respect of his hospital-based practice (Health Sciences North – Sudbury), Dr. Malette shall retain a Supervising Practice Monitor acceptable to the College who has executed the Supervising Practice Monitor's undertaking in the form attached to the Order as Appendix "B".
    f) Dr. Malette shall inform his patients of the indication for any pelvic, genital and/or rectal examination that he may perform, and shall document the discussion in the corresponding patient chart.
    g) Dr. Malette shall ensure that both in respect of his office-based practice and his hospital-based practice the Practice Monitors maintain a log of all pelvic, genital and/or rectal examinations he conducts in the form attached to the Order as Appendix "B," including listing the indication Dr. Malette described to his patient for any pelvic, genital and/or rectal examination performed and confirming that Dr. Malette has documented the discussion in the corresponding patient chart. Dr. Malette shall maintain up to date copies of

the Logs by ensuring copies are made at the end of each business day, and shall make them available to the College upon request. Dr. Malette shall ensure that the original Logs are submitted to the College on a monthly basis.

h) Dr. Malette shall ensure that each patient with whom he intends to conduct a pelvic, genital and/or rectal examination is directly notified, prior to the examination, of the details of the restriction described in paragraph 4(c).
i) Dr. Malette shall post a sign in all waiting rooms, examination rooms and consulting rooms of his office-based practice in a clearly visible and secure location, in the form set out in Appendix "C", that states: "Dr. Paul Malette must not conduct pelvic, genital and/or rectal examinations of any kind unless in the continuous presence of and under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Dr. Malette must not be alone with patients during pelvic, genital and/or rectal examinations. Further information may be found on the College website at www.cpso.on.ca."
j) Dr. Malette shall provide each patient with whom he intends to conduct a pelvic, genital and/or rectal examination in his hospital-based practice with a copy of the sign in the form set out at Appendix "C" to the Order. Dr. Malette shall ensure that prior to the pelvic, genital and/or rectal examination, the patient (or their next of kin if the patient is incapable) initials the sign, along with the date of their signature, and that a copy of the initialed and dated sign is maintained in the patient chart.
k) Dr. Malette shall obtain a certified translation, in any language in which he provides services, of the sign described in paragraph 4(i). He shall post it in all waiting rooms, examination rooms and consulting rooms, in all of his office-based practice locations, in a clearly visible and secure location, in the form set out at Appendix "C" to the Order. He shall have copies readily available to him in his hospital-based practice, in the form set out at Appendix "C" to the Order.
l) Dr. Malette shall provide the certified translation described in paragraph 4(k), to the College within thirty (30) days of the date of the Order.
m) Dr. Malette shall inform the College of each and every location at which he practises or has privileges including, but not limited to hospitals, clinics, offices, and any Independent Health Facilities with which Dr. Malette is affiliated, in any jurisdiction (collectively "Practice Location" or "Practice Locations"), within five days of the Order. Going forward, Dr. Malette shall undertake to inform the College of any and all new Practice Locations within five days of commencing practice at that location. If Dr. Malette carries on an office- or clinic-based practice at a new Practice Location, the provisions of paragraphs 4(c), (d), (f), (g), (h), (i), (k), and (l) above describe the practice monitoring arrangements that will be required at that location. If Dr. Malette carries on a hospital-based practice involving seeing in-patients and/or emergency department patients at a new Practice Location, the provisions of

paragraph 4(c), (e), (f), (g), (h), (j), (k), and (l) above describe the practice monitoring requirements that will be required that that location.

n) Dr. Malette shall submit to and shall not interfere with unannounced inspections of his Practice Locations and to the inspection of patient records by the College and to any other activity the College deems necessary in order to monitor his compliance with the provisions of the Order.
o) Dr. Malette shall execute the OHIP consent form, in the form attached at Appendix “E” to the Order.

4. Dr. Malette to pay costs to the College in the amount of $10,370 within 30 days of the date of the Order.

Council Briefing Note

March 2020

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Policy Consultation Update:

    I. *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education*
    II. *Third Party Reports* and *Medical Expert: Reports and Testimony*

2. Policy Status Table

---

1. Policy Consultation Update

I. *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education*

- The preliminary consultation on the *Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education* policies began following December Council and closed on February 12, 2020.

- The consultation garnered a total of 94 responses: 23 through written feedback and 71 via the online survey.[1]

- Respondents, though generally supportive of the existing expectations set out in the policies, raised a number of issues, including:

    - Revising the policies to prohibit sexual relationships between supervisors and residents/medical students;

[1] Organizational respondents included: Information and Privacy Commissioner of Ontario (IPC), #MedicineToo, Ontario Coalition of Rape Crisis Centres (OCRCC), Ontario Medical Association (OMA), Professional Association of Residents of Ontario (PARO), Society for Canadians Studying Medicine Abroad (SOCASMA), and Undergraduate Education Committee of the Council of Ontario Faculties of Medicine (UE:COFM).

- Clarifying when supervisors need to be physically present;
- Addressing the ability of patients being able to refuse having a medical student observe or participate in the care provided to them while balancing the need for medical students to receive comprehensive training;
- Strengthening the policies with respect to addressing intimidation and harassment of medical students and residents by supervisors or most responsible physicians (MRPs); and
- The supervision of students by other regulated health professionals.

- All feedback is currently being reviewed in detail and will help inform revisions to the policy.

II. *Third Party Reports* and *Medical Expert: Reports and Testimony*

- The preliminary consultation on the *Third Party Reports* and *Medical Expert: Reports and Testimony* policies began following December Council and closed on February 12, 2020.

- The consultation garnered a total of 210 responses: 52 through written feedback and 158 via the online consultation survey.[2]

    - Additionally, FAIR[3] has actively promoted the consultation which has generated moderate social media engagement on these issues with patients and other advocates.

- Overall, respondents found the current policies to be clear and comprehensive and the expectations to be reasonable. However, many respondents expressed concern that the policies were not being complied with in practice. Specific feedback received on some key issues is highlighted below:

    - The majority of survey respondents thought physicians need to be actively practicing medicine in order to maintain the knowledge and expertise

[2] Organizational respondents included: Acquired Brain Injury Survivor Solutions (ABISS), AssessMed, Canadian Life and Health Insurance Association Inc. (CLHIA), FAIR Association of Victims for Accident Insurance Reform (FAIR), Functional Rehabilitation Inc., Injured Workers Community Legal Clinic (IWC), Insurance Bureau of Canada (IBC), Information and Privacy Commissioner of Ontario (IPC), Life Insurance Industry, Ontario College of Family Physicians (OCFP), Ontario Medical Association (OMA), Ontario Network of Injured Workers Group (ONIWG), Ontario Rehab Alliance, Ontario Trial Lawyers Association (OTLA), Professional Association of Residents of Ontario (PARO), and a Worker's Compensation representative.

[3] FAIR is a grassroots not-for-profit organization of victims who have been injured in motor vehicle collisions and who have struggled with the current auto insurance system in Ontario.

required to assess and/or provide an opinion on a matter for a third party process.
  - Some respondents[4] thought family physicians shouldn't be obligated to provide third party reports for patients in certain circumstances, such as: when multiple requests for the same information are made, and when other health care providers (e.g. specialists) may be better positioned to provide them.
  - Some respondents[5] suggested it be mandatory for all physicians who participate in a third party process to disclose any actual or potential conflict of interest.
  - Some organizational respondents[6] and the majority of survey respondents thought it is inappropriate for third party reports to be 'ghostwritten' (reports drafted by someone other than the physician) and suggested that this practice be prohibited, or at the very least, that there be greater transparency in the report regarding the author of content.
  - Some respondents[7] suggested clarifying physicians' obligations with respect to comprehensiveness, relevance, and accuracy.
  - Some respondents[8] suggested clarifying physicians' obligations with respect to consent, and suspicious findings during independent medical examinations (IMEs).
  - Many respondents[9] suggested clarifying the expectations regarding the involvement of observers and recordings during IMEs, with the majority of respondents recommending observers or recordings be required for every IME.
  - The majority of survey respondents thought either a 60-day timeframe or not quantifying the timeframe for submitting reports was reasonable, and less than half of survey respondents thought a 30-day timeframe was reasonable.
  - A range of comments were provided on fees, including: physicians should be appropriately compensated for third party reports; and an independent third party (e.g. government) should pay for third party reports to help reduce bias in favor of the payee.

- All feedback is currently being reviewed in detail and will help inform revisions to the policies.

[4] Including: OCFP.
[5] Including: IBC.
[6] Including: IBC, OTLA, ABISS, FAIR, and a Worker's Compensation representative.
[7] Including: OMA, CLHIA, OTLA, and IWC.
[8] Including: OMA, IPC, CLHIA, OTLA, PARO, and FAIR.
[9] Including: OTLA and FAIR.

2. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix A**. This table will be updated at each Council meeting.

- For further information about the status of any policy issue, please contact Craig Roxborough, Manager, Policy, at extension 339.

DECISION FOR COUNCIL:

1. For information only.

Contact: Craig Roxborough, Ext. 339.

Date: February 13, 2020

Attachments:

Appendix A: Policy Status Table

Policy Status Report – March 2020 Council

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle					Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Revising Draft Policy	Final Approval		
Professional Responsibilities in Postgraduate Medical Education & Professional Responsibilities in Undergraduate Medical Education	Dec-19		✓				**2021**	A joint review is being undertaken to review and update each policy.
Medical Expert & Third Party Reports	Dec-19		✓				**2021**	A joint review is being undertaken to review and update each policy.
Advertising	May-19			✓			**2020**	A *new* policy is being developed to provide guidance on and set parameters within an existing legislative framework.
Complementary/ Alternative Medicine	Mar-19		✓				**2020**	
Delegation of Controlled Acts	Mar-19		✓				**2020**	
Medical Records	Sept-17					✓	**2020**	Two revised draft policies have been developed called: *Medical Records Management* & *Medical Records Documentation*
Confidentiality of Personal Health Information	May-17					✓	**2020**	The revised draft policy has been retitled: *Protecting Personal Health Information*
Statements & Positions Redesign	Jan-20		✓				**2020**	All CPSO *Statements & Positions* are being evaluated for relevance, currency, and potential updates.

Policy Status Report – March 2020 Council

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Female Genital Cutting (Mutilation)	2016/17	Medical Assistance in Dying	2021/22
Dispensing Drugs	2016/17	Accepting New Patients	2022/23
Mandatory and Permissive Reporting	2017/18[1]	Ending the Physician-Patient Relationship	2022/23
Social Media – Appropriate Use by Physicians (Statement)	2018/19	Uninsured Services: Billing and Block Fees	2022/23
Providing Physician Services During Job Actions	2018/19	Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24
Physicians' Relationships with Industry: Practice, Education and Research	2019/20	Public Health Emergencies	2023/24
Telemedicine	2019/20	Closing a Medical Practice	2024/2025
Cannabis for Medical Purposes	2020/21	Availability and Coverage	2024/2025
Professional Obligations and Human Rights	2020/21	Managing Tests	2024/2025
Consent to Treatment	2020/21	Transitions in Care	2024/2025
Planning for and Providing Quality End-of-Life Care	2020/21	Walk-in Clinics	2024/2025
Blood Borne Viruses	2021/22	Disclosure of Harm	2024/2025
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	Prescribing Drugs	2024/2025
Physician Behaviour in the Professional Environment	2021/22	Boundary Violations	2024/2025

[1] A comprehensive update to this policy was completed as part of the Policy Redesign process. Council approved this updated version in September 2019.

Council Briefing Note

March 2020

TOPIC: **Governance Committee Report:**

1. **New Members of Council**
2. **Committee Appointments**

FOR INFORMATION

---

1. New Members of Council:

- The following public member reappointment/appointments have been made by the Lieutenant Governor of Ontario by Order in Council (Appendix A):

Public Member Reappointment:		Date	Term
Mr. Pierre Giroux	Toronto	December 5, 2019	3 years
Public Member Appointments:		Date	Term
Ms. Nadia Joseph	London	December 20, 2019	3 years
Dr. Lydia Miljan, PhD	Kingsville	January 1, 2020	3 years
Mr. Jose Cordeiro	Markham	January 31, 2020	1 year

- **Dr. Karen Saperson** commenced her appointment as Academic Representative from McMaster University on February 7, 2020.

2. Committee Appointments

- The Executive Committee made the following ICR Committee appointments at the February 4, 2020 meeting:
-
    - Dr. Lara Kent, Family Medicine
    - Dr. Brian Watada, Family Medicine
    - Dr. Thomas Bertoia, Orthopaedic Surgery

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, 503
Marcia Cooper, 546
Debbie McLaren, 371

Date: February 13, 2020

Attachments:

Appendix A: Orders in Council for Public member Reappointment/Appointments

Ontario

Appéndix A

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*, **Pierre Giroux** of Toronto be reappointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding three years, effective December 5, 2019.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins*, **Pierre Giroux** de Toronto est reconduit au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale de trois ans, à compter du 5 décembre 2019.

Christine Elliott

Recommended: Minister of Health
Recommandé par : La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered: NOV 2 8 2019
Approuvé et décrété le :

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 1750/2019

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*, **Nadia Joseph** of London be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding three years, effective December 20, 2019 or the date this Order in Council is made, whichever is later.

- - - - - - -

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins*, **Nadia Joseph** de London, est nommée au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale de trois ans, à compter du dernier en date du 20 décembre 2019 et du jour de la prise du présent décret.

Christine Elliott

Recommended: Minister of Health
Recommandé par: La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered:
Approuvé et décrété le : DEC 0 6 2019

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 1810/2019

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*, **Lydia Miljan** of Kingsville, be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding three years, effective January 1, 2020.

- - - - - - -

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins*, **Lydia Miljan** de Kingsville, est nommée au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale de trois ans, à compter du 1er janvier 2020.

Christine Elliott

Recommended: Minister of Health
Recommandé par: La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered: DEC 0 6 2019
Approuvé et décrété le :

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 1809/2019

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991,* **Jose Cordeiro** of Markham, be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding one year, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins,* **Jose Cordeiro** de Markham, est nommé au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario, pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale d'un an à compter du jour de la prise du présent décret.

Christine Elliott

Recommended: Minister of Health
Recommandé par : La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered:
Approuvé et décrété le : JAN 3 1 2020

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 178/2020

Council Briefing Note

March 2020

TOPIC: **Governance Committee Report:**

- **Acceptance of One Voting Academic Representative on Council**

FOR DECISION

ISSUE:

- Council is asked to accept a recommendation from the *Academic Advisory Committee* for Dr. Janet van Vlymen, academic representative from Queen's University, to fill a vacancy for one voting Academic Representative on Council.

BACKGROUND:

- Current members of the *Academic Advisory Committee (6 academic representatives appointed by Dean of each of the 6 Ontario medical schools)* are:
    - Dr. Mary Jane Bell, University of Toronto
    - Dr. Paul Hendry, Ottawa University
    - Dr. Terri Paul, Western University
    - Dr. Karen Saperson, McMaster University *(new appointment - February 7, 2020)*
    - Dr. Robert Smith, Northern Ontario School of Medicine
    - Dr. Janet van Vlymen, Queen's University
- At the September 2019 meeting of Council, Council accepted a recommendation from the *Academic Advisory Committee* for the following three voting academic representatives to Council for the 2019-2020 Council session:
    - Dr. Akbar Panju
    - Dr. Paul Hendry
    - Dr. Robert Smith
- As a result of Dr. Akbar Panju's recent resignation from Council, as McMaster University representative, there is a current vacancy on Council for one voting academic representative.

DECISION FOR COUNCIL:

1. Council will decide whether to accept the *Academic Advisory Committee's* recommendation for Dr. Janet van Vlymen to fill the vacancy for one voting academic representative to Council for 2020. [If not approved, a vote by ballot will be held to elect one of the 4 members of the *Academic Advisory Committee* who are not currently voting academic members.]

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, 503
Marcia Cooper, 546
Debbie McLaren, 371

Date: February 13, 2020

Council Motion

Motion Title: Appointment of Vice President and Executive Member Representative to 2020 Executive Committee

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario appoints _____, (as Vice President) and _____, (as Executive Member Representative) to the 2020 Executive Committee.

CPSO

Council Briefing Note

March 2020

TOPIC: **Governance Committee Report:**

- **Vote for Vice President for 2020 Executive Committee**

FOR DECISION

ISSUE:

- There is a current vacancy for the position of Vice President on the 2020 Executive Committee. A vote will take place at the March 6 meeting of Council to fill the vacancy for Vice President, and, if applicable, to fill one vacancy for an Executive Member Representative of Council.

BACKGROUND:

- The current composition of the 2020 Executive Committee is:
    - Dr. Brenda Copps, President
    - Vacancy, Vice President
    - Dr. Judith Plante, Executive Member Representative
    - Dr. Peeter Poldre, Past President
    - Ms. Ellen Mary Mills, Executive Member Representative
    - Mr. Peter Pielsticker, Executive Member Representative

- Council was provided with a memo from the Chair of Governance Committee describing the nomination and election process to fill the vacancy for Vice President. (See Appendix A)

- Nomination Statements for the vacant positions of Vice President and Executive Member Representative have been received from (see Appendix B):
    - Mr. Peter Pielsticker – candidate for Vice President
    - Dr. Judith Plante – candidate for Vice President
    - Dr. Janet van Vlymen – candidate for Executive Member Representative

- At the December 2018 Council meeting, Council approved amendments to the General By-Law, subsections 28, 32 and 39 to support opening up the College president and vice-president positions to public Council members.
- If the only candidates for the Vice President position are current members of the 2020 Executive Committee, there will be a vacancy for one Executive Member Representative of Council on the 2020 Executive Committee.
- As per the General By-Law, subsection 39(1), the Executive Committee is required to have a minimum of 2 physician members and 2 public members of Council. This requirement has been satisfied in the current committee composition. Accordingly, the sixth Executive Member Representative may be a physician or public Council member.
- Nomination Forms with signature of nominee, mover and seconder are due, prior to the commencement of the Council meeting on Thursday, March 6, 2020.
- Nominees will be given the opportunity to address Council, prior to the election.

DECISION FOR COUNCIL:

1. Election for 2020 Executive Committee positions; 1 Vice President and 1 Executive Member Representative of Council.

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, 503
Marcia Cooper, 546
Debbie McLaren, 371

Date: February 13, 2020

Attachments:

Appendix A: Memo to Council regarding Nomination/Election Process for the Vote for Vice President, and if applicable, Executive Member Representative for the 2020 Executive Committee

Appendix B: Nominations Statements for Vice President and Executive Member Representative Candidates

Appendix A

Memorandum

To	All Council Members
From	Dr. Peeter Poldre, Chair, Governance Committee
Date	January 23, 2020
Subject	Nomination/Election Process for the Vote for Vice President, and if applicable, Executive Member Representative, at the March 6, 2020 meeting of Council

---

There is a current vacancy for the office of Vice President on the Council. This vacancy needs to be filled for the remainder of the 2020 Council year.

In order to fill this vacancy at the March 2020 Council meeting, an election will be held for the Vice President position and, if applicable, for an Executive Member Representative, as prescribed in the General By-Law, subsection 28.

The current composition on the 2020 Executive Committee is:

President:	Dr. Brenda Copps (physician)
Vice President:	Vacancy
Past President:	Dr. Peeter Poldre (physician)
Executive Member Rep:	Dr. Judith Plante (physician)
Executive Member Rep:	Ms. Ellen Mary Mills (public member)
Executive Member Rep:	Mr. Peter Pielsticker (public member)

- The Vice President can be a physician or public member on Council, since the requirement in By-law Section 39 for a minimum of two public members and a minimum of two physician members on the Executive Committee have already been met.
- Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.
- If the Vice President position is filled by a Council member who is not currently a member of the 2020 Executive Committee, the Executive Committee slate will be complete for 2020 and no further election will be required.

- **If the Vice President position is filled by one of the current Executive Member Representatives on the 2020 Executive Committee, there will be a further election for an Executive Member Representative** (who can be physician or public member of Council).
- If there is an election for an Executive Member Representative, Council members (other than those already on the Executive Committee) who ran for Vice-President position but were not elected, may run for the Executive Member Representative position, if they wish.

Council is reminded of the established convention of having the Vice President position progress to the President position for the following Council year to ensure an incoming President has a minimum of one-year experience on the Executive Committee. Accordingly, the person who becomes the Vice President for the remainder of the 2020 Council year is expected, by convention, to progress to be the President for the 2020/2021 Council year, commencing at the 2020 December Council meeting.

All Council members who wish to be nominated for either the Vice President or the *potential* Executive Member Representative position on the 2020 Executive Committee are invited to submit a ***Nomination Statement*** and indicate the elected position(s) they are running for.

Nomination Statements assist Council members to identify candidates who are running for election and provide more information regarding a candidate's background, qualifications and reasons for running for an Executive Committee position. The ***Nomination Statement*** is limited to 200 words. ***Nomination Statements*** will include brief biographical information and a photo of the candidate.

In addition to your *Nomination Statement*, a completed ***Nomination Form*** (see attached) which contains the signature of a nominee, as well as his or her nominator and seconder, for each position a candidate is running for, is due prior to the commencement of the Council meeting on Friday, March 6, 2020. The nominator and seconder must both be voting Council members.

Timeframe and Process for Executive Committee Nominations:

1. Please forward your request for a personalized ***Nomination Statement*** to Debbie McLaren at dmclaren@cpso.on.ca
2. The deadline for submission of your completed ***Nomination Statement***(s) is **Friday, February 7, 2020**.
3. ***Nomination Statements*** will be circulated to Council members in the Governance Committee Report to Council and sent by separate e-mail, prior to the March Council meeting.
4. The deadline for your signed ***Nomination Form*** is **Friday, March 6, 2020,** prior to the commencement of the Council meeting.
5. Nominations from the floor will be accepted during the Governance Committee Report on the day that the vote takes place.
6. Prior to the vote, each nominee will be given an opportunity to address Council about his/her candidacy for the office or position.
7. The position(s) voted on at the March 6, 2020 Council meeting will commence after the successful nominees are appointed, by motion, at the meeting.

If you have any questions regarding the 2020 Executive Committee nomination process for the vacant positions, please contact Laurie Cabanas at lcabanas@cpso.on.ca or, alternatively, by phone at 416-967-2600, ext. 503, or toll free: 1-800-268-7096, ext. 503 or you can contact myself at ppoldre@cpso.on.ca

Thank you,

Peeter A. Poldre, MD, EdD, FRCPC
Chair, Governance Committee

Attachments: Nomination Forms for Vice President and Executive Member Representative

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR VICE PRESIDENT:

I _____ am willing to be
Print name here

nominated for Vice President.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR EXECUTIVE MEMBER REPRESENTATIVE:

I _____ am willing to be
Print name here

nominated for Executive Member Representative.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

NOMINATION STATEMENT
CANDIDATE FOR 2020 EXECUTIVE COMMITTEE
VICE PRESIDENT

MR. PETER PIELSTICKER, CA, CPA

Public Member of Council
Tehkummah, Ontario

Occupation: Financial Consulting

Appointed Council Terms:
March 18, 2015 – March 17, 2018
March 18, 2018 – December 31, 2018
January 1, 2019 – June 30, 2019
July 1, 2019 – June 30, 2022

CPSO Committees and Other CPSO Work:

Discipline Committee:	2015 - 2020
Executive Committee:	2019 - 2020
Finance and Audit Committee:	Chair: 2017 - 2020, Member: 2015 - 2017
Staff Pension Committee:	2018 - 2020
Premises Inspection Committee:	2015 - 2020
Quality Assurance Committee:	2015 - 2020

STATEMENT:

We were all disappointed to hear of Dr. Panju's resignation. We will miss his contribution and thank him for the skills and knowledge he brought to us. Unexpectedly, there is now a vacancy to fill and I ask for your confidence that I can fill the role of Vice-President. I am not a physician; I am a CPA, a professional accountant who would bring to this role my business experience as CFO of a public company and related C suite know how.

Since coming to the CPSO in 2015 I have now served on many committees as outlined above and through my service I have gained great respect for the profession of medicine, its commitment, its unique demands, its responsibility to serve the public. The President of the College must speak to the profession and to the public, of our trust, our commitment—to provide the best care, the most honorable dedication to the public good.

As a public member, now experienced in the workings of the College, I can bring a fresh perspective in keeping with the new look. I want to be part of that transformation and ask for your support to help to make this happen.

NOMINATION STATEMENT
CANDIDATE FOR 2020 EXECUTIVE COMMITTEE
VICE PRESIDENT

DR. JUDITH PLANTE

District 7 Representative
Pembroke, Ontario

Principal Area of Practice: Family Medicine

Elected Council Terms:
December 4, 2015 – December 7, 2018
December 7, 2018 – December 3, 2021

CPSO Committees and Other CPSO Work:

Executive Committee:	2019 - 2020
Inquiries, Complaints and Reports Committee:	2015 - 2020, Vice Chair, Family Practice, 2019 - 2020
Registration Committee:	2016 - 2020, Acting Chair, 2020
Policy Working Groups: *Medical Records*	Chair: April 2018 - 2020

STATEMENT:

Council is currently facing the challenges of implementing reform to our governance structures and modernizing our interactions with our members and the public. We need to make these changes while respecting the core values and mandate of the institution.

I submit that I have the skills to help lead this work. I also have the time as, after 27 years, I have retired from full time clinical practice. My background as a small town non-GTA physician gives me a unique perspective among the present Executive.

I am in my 5th year on Council and my CPSO experience and ongoing contributions are noted above. My work experience before coming to the CPSO was broad based and includes experience as a clinician, medical educator, and hospital department chief.

Good communication skills, common sense, the ability to be a team player and to seek solutions co-operatively are all attributes that I pride myself on. I am humbly asking you for the opportunity to use these skills to help lead Council's efforts in 2020 as the Vice President.

Thank you.

Dr. J. Plante, MDCM, CCFP, FCFP

NOMINATION STATEMENT
CANDIDATE FOR 2020 EXECUTIVE COMMITTEE
EXECUTIVE MEMBER REPRESENTATIVE

DR. JANET van VLYMEN

Queen's University Academic Representative
Kingston, Ontario

Principal Area of Practice: Anesthesiologist

Appointed Council Terms:
December 2, 2016 – December 4, 2020

CPSO Committees and Other CPSO Work:

Education Committee:	2016 - 2019
Academic Advisory Group:	2020 (Chair)
Quality Assurance Committee:	2016 - 2020
Policy Working Group: *Prescribing Drugs*	2018 - 2019
Policy Review Working Group: *(formerly Policy Redesign Working Group)*	2019 - present

STATEMENT:

Thank you for considering me for a position on the Executive Committee. I am an anesthesiologist with over 20 years' experience at Queen's. Early in my career, I was appointed Director of Pre-Surgical Screening where I created a stream-lined, patient-centred program to prepare patients for surgery. As Deputy Chief, I continued to develop policies and procedures to improve patient safety. I am now the Program Medical Director for Perioperative Services with accountability for the quality of care for all patients, throughout their surgical experience.

I first worked with the CPSO as an investigator for ICRC and PIC as a medical expert. In 2016, I was appointed Academic Representative for Queen's University and joined the QAC and Education Committees. I have been fortunate to be involved in a variety of working groups and was a member of the Policy Redesign project last year. As a strong advocate for high-quality patient care, I am grateful for the opportunity to work with the diverse group of physician and public members on Council. If elected to the Executive Committee, I have the support of my Chair to allow me more time away from my Department, and also support of the Dean, to continue working on Council without the risk of losing my position during re-election.

Council Orientation to CPSO

(no materials)

Registrar/CEO's Report

(no materials)

President's Report

(no materials)

Council Briefing Note

March 2020

TOPIC: Application Health Questions – Management and Messaging

FOR DISCUSSION

ISSUE:

- An overview of the College's approach to the management of health-related questions and information arising out of the College's application process.

BACKGROUND:

- The College is charged with ensuring public protection and, as part of our duties, needs to be assured that all physicians applying for registration meet the non-exemptible requirements in Subsection 2(1) of Ontario Regulation 865/93. With respect to health information, the College needs to be satisfied that a physician:

  (a) is mentally competent to practise medicine;
  (b) will practice medicine with decency, integrity and honesty and in accordance with the law;
  (c) has sufficient knowledge, skill and judgement to engage in the kind of medical practice authorized by the certificate; and
  (d) can communicate effectively and will display an appropriately professional attitude

- The questions in the application form that ask about personal health are designed to elicit responses to help satisfy the College that an individual meets the non-exemptible criteria, and specifically to ascertain that a physician is not suffering from a health condition that may impact their ability to practise safely.

- The College's past approach to managing existing or historical mental health conditions disclosed throughout the application process has created a fear amongst learners that the College applies a heavy-handed approach.

CURRENT STATUS:

- In the last few years the application questions have been modified and our protocols updated to emphasize support and to reduce the stigma of acknowledging a mental health condition in College applications.

- The current questions in the application form **do not** distinguish between physical and mental health – they are broadly designed and ask applicants to disclose whether they have had or currently have a medical condition which has or could affect their ability to practice.

- The only specific health related question that the application asks is with respect to abuse of/dependence on alcohol or drugs.

- Many instances of positive responses (disclosure of health conditions) satisfy Section 2 of the regulation with an applicant's explanation, and **do not** require any follow up information.

- In the case of an individual who suffers from a chronic health condition, the College would seek confirmation to determine whether it is a recurring condition that **may** impact their ability to practice. If an individual sought/is seeking appropriate care and treatment and the condition is well maintained, the College would be satisfied and there would likely be no further consideration

- If, on the other end of the spectrum, we receive information that the individual has no insight into their condition, or that their condition is not well maintained, this individual would be referred to the Registration Committee.

- For individuals who acknowledge that they abuse or are dependent/addicted on alcohol or drugs –the College would ensure that they are involved with the Physician's Health Program (PHP) or alternate program.

- All cases are considered individually, but it would be very **unlikely** for a physician to be denied registration based on an underlying medical condition.

- In a matter where an applicant is not seeking treatment for a diagnosed medical condition – we would refer this case to the Registration Committee who would likely defer making judgment on their application until we can ensure that appropriate treatment/monitoring is in place.

CONSIDERATIONS:

- In all instances, the information obtained through the application process is confidential.

- The College does not distinguish between how we process applications with physical health vs mental health conditions – same approach (ie request for same documentation, etc) is taken.

- Since instituting the changes in procedures and providing increased clarity surrounding the application questions, we have seen a 93% reduction in matters being referred to the

Registration Committee for consideration, and of those referred, we have seen an 87.5% reduction in matters requiring a referral to the PHP.

- The College is committed to a balanced approach; one that that protects the patient while respecting the privacy of physicians with medical conditions.

NEXT STEPS:

- We continue to work to shift the dialogue with the membership and applicants to be one of support and reduce the stigma that may have existed in the past relating to the College's management of health questions.

- From October 2019 – December 2019 the College engaged in discussions/presentations with OMSA, PARO, OMA and UE COFM surrounding the College's practice with respect to its management of health conditions (see above);

- These meetings included providing detailed descriptions of our practice and examples in writing to assist.

- The New Member Orientation (NMO) which will launch in March of this year and be available to all new applicants, has a comprehensive module that deals with Wellness – specifically physician wellness, stress and burnout, available resources and the Physician Health Program (PHP).

- As part of the SOLIS project, all application questions, including health questions, are currently under review. We anticipate providing additional clarity, supportive language and providing further direction via help text entrenched in the application form to assist applicants when completing the forms

- In 2019 the College created a *Physicians in Distress and Crisis Management* working group – which resulted in the development of protocols and tools to identify and support both physicians and staff.

- An article which details the College's management of health conditions is currently being drafted for *Dialogue*;

- We will continue to support the undergrad and postgrad offices to dispel some of the rumors that exist regarding the application process and management of health-related information by attending their offices for an FAQ session on an ongoing basis.

DISCUSSION FOR COUNCIL:

1. Do the strategies/supports recommended to socialize the College's approach to management of health-related questions in the application form meet Council's needs?

Contact: Samantha Tulipano

Date: February 18, 2020

Council Briefing Note

March 2020

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the March 6 meeting of Council, **Dr. Steven Griffin** of Bancroft will receive the Council Award.

BACKGROUND:

The Council Award identifies and describes the abilities physicians require to effectively meet the health care needs of the people they serve. These abilities are grouped thematically under seven roles. A competent physician seamlessly integrates the competencies of all seven Council Award qualities:

- The physician as medical expert (the integrating role)
- The physician as communicator
- The physician as collaborator
- The physician as leader
- The physician as health advocate
- The physician as scholar
- The physician as professional

CURRENT STATUS:

Council member Dr. John Rapin will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Vanessa Clarke, Ext. 773
Date: February 10, 2020

Council Motion

Motion Title: Medical Records Policies

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policies “Medical Records Management” and “Medical Records Documentation”, formerly titled “Medical Records”, (copies of which form Appendices “ ” and “ “ to the minutes of this meeting).

CPSO

Council Briefing Note

March 2020

TOPIC: *Medical Records* – Revised Policies for Final Approval

FOR DECISION

ISSUE:

- The College's *Medical Records* policy is currently under review. In September 2019, Council released two new draft medical records policies, retitled *Medical Records Stewardship* and *Medical Records Documentation,* for external consultation. The draft policies have been revised in light of the feedback received through this engagement activity.

- Council is provided with an overview of the changes and is asked whether the revised draft policies can be approved as policies of the College.

BACKGROUND:

- The current *Medical Records* policy was approved by Council in 2012. A Working Group was struck to undertake the current policy review, consisting of Judith Plante (Chair), Robert Gratton, and Akbar Panju, with support from Angela Carol (Medical Advisor) and Lindsay Cader (Legal Counsel).

- Following extensive research[1] and a preliminary consultation[2], two new draft medical records policies were developed and approved for external consultation by Council in September 2019. The accompanying *Advice to the Profession* documents were also released at this time.

---

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and international medical regulatory authorities; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee (ICRC); and feedback on the current policy from the College's Public and Physician Advisory Service and staff in the QA/QI department.

[2] 58 responses were received which included 17 comments on the College's online discussion page and 41 online surveys. An overview of the feedback was provided to Council in December 2017 as part of the Policy Report.

- 128 responses were received as part of this engagement activity.[3] Overall respondents found the draft policies to be clear and comprehensive, the expectations to be reasonable, and there was general support for separating the expectations into two draft policies.

- All feedback received has been posted on a dedicated page of the College's website, along with a comprehensive report of the survey results. A preliminary overview of the feedback was provided to Council in the December 2019 Policy Report.

CURRENT STATUS:

- In response to stakeholder feedback from the general consultation, the draft *Medical Records Management* (formerly titled *Medical Records Stewardship*) **(Appendix A)** and *Medical Records Documentation* **(Appendix B)** policies have both been revised and updates have been made to the draft *Advice* documents **(Appendix C** and **Appendix D).**

- The majority of the expectations in the draft policies have been retained, however some revisions have been made, primarily to enhance clarity, align with legislation, and reflect the realities of practice. An overview of the key revisions is provided below.

A. Key Additions and Revisions: *Medical Records Management*

Policy Title

- The policy title has been revised and is now *Medical Records Management.* Feedback suggested that the previous title ("Stewardship") was not understandable to the public and there was some confusion about the distinction between *stewardship* and *custodianship.*

Establishing Custodianship and Accountabilities

- The draft provision requiring physicians with shared record-keeping systems to have written agreements about records has been updated to also require physicians who are not the owners of clinics and/or of the EMR licence to have written agreements about medical records (Provision #2b).

    - The draft expectation was developed in response to frequent complaints, disputes, and ambiguity regarding ownership of records, but did not sufficiently address conflicts between physicians and clinic owners (often not health care providers).
    - Feedback suggested that such conflicts can prevent physicians from meeting their professional obligations regarding records.

[3] 42 written responses and 86 survey responses. The majority of respondents were physicians.

- Additional information about what to address in agreements has also been included in the revised draft policy (Provision #3c) along with a footnote that directs physicians to additional resources for establishing agreements (Canadian Medical Protective Association (CMPA) and the Ontario Medical Association (OMA)) (footnote #3).

Conflicts over records impacting patient care

- In response to feedback from the CMPA and the OMA that conflicts regarding medical records are not always within the physician's control, the draft policy has been revised and requires physicians to take *"all reasonable steps within their control"* to prevent a conflict over medical records from compromising patient care (Provision #6).

Fees and Invoicing

- In response to frequent complaints about unreasonable fees for copies of medical records and a suggestion from a member of ICRC, the draft policy has been updated to require physicians to provide an itemized bill that provides a breakdown of the cost, upon request (e.g. identifying the cost per page, cost for transfer, etc.) (Provision #15b). This expectation is consistent with the *Professional Misconduct Regulation* which sets out that it is considered professional misconduct to not provide an itemized bill when requested.[4]

Considering a patient's ability to pay

- In response to questions from Council and Committee members about how physicians can determine a patient's ability to pay for a copy of their medical records, the *Advice* document has been updated to provide guidance in this regard (Lines 186 – 205).

- The policy expectations and additional guidance provided are consistent with the *Uninsured Services: Billing and Block Fees* policy and *Advice*, as well as the Canadian Medical Association's *Code of Ethics and Professionalism*[5].

Charging for a review of records prior to transfer

- Stakeholders requested additional and, in some cases, revised guidance regarding charging for a review of records prior to transfer. Most feedback expressed that the draft policy does not go far enough to limit unreasonable fees for a review of records, while the OMA suggested that the draft *Advice* should be amended to be more permissive.

---

[4] Section 1(1) paragraph 24 of the Professional Misconduct, O. Reg. 856/93 enacted under the *Medicine Act, 1991,* S.O. 1991, C.30.

[5] The Canadian Medical Association's *Code of Ethics and Professionalism* (#26) states that physicians have an ethical and professional responsibility to "Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees."

- In response, guidance in the *Advice* document has been revised to emphasize that there are limited circumstances where a review beyond 15 minutes would be warranted and that it is inappropriate to charge for a review to ensure that records are accurate and complete as this is already a requirement (Lines 174 - 185).

    - Charging excessive fees for a review of records prior to transfer was a concern raised by ICRC and has been echoed in the consultation feedback.
    - The Working Group is of the view that the expectations regarding reasonable fees along with additional guidance in the *Advice* should help address this issue.

Additional security provisions

- In response to feedback from the Information and Privacy Commissioner of Ontario (IPC) updates were made to require physicians with custody or control of electronic records to ensure each user accessing the system has a separate user ID and password, and an audit trail is maintained for all accesses (views) of personal health information even where no changes are made to the record (Provision #28). Additional references to best practices offered by the IPC are set out in the *Advice*.

Use of certified EMRs

- The draft policy included a new provision requiring physicians to only use certified electronic record-keeping systems (e.g., EMRs) unless they could verify that an unaccredited system meets privacy and security standards set out in legislation[6] and regulation[7]. The draft directed physicians to OntarioMD (OMD) and Canada Health Infoway (Infoway) for EMRs that are certified for privacy.

- This position has been revised to focus on ensuring compliance with *PHIPA* and the Regulation instead of requiring certification (Provision # 30). The *Advice* continues to highlight the benefits of using EMRs that are certified by OMD.

    - While there was broad support for this provision in the consultation, there is actually no official accreditation body in Ontario or Canada (notwithstanding OMD and Infoway's 'certification' offerings).

Use of EMRs that provide efficient access to information

- The draft policy also included an existing expectation to use electronic systems that provide efficient access to patient information. Feedback suggested that efficiency may be difficult

[6] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (*PHIPA*).
[7] Part V of the General, Ontario Regulation 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (the Regulation).

to assess or sometimes difficult to achieve given EMR structures, and so the policy was revised to focus on ensuring the electronic system is able to capture all pertinent information (Provision # 30).

Advice Document

- In response to feedback and requests for additional information, the *Advice* document has been updated to address the following additional issues:

    - Importance of establishing records contracts as soon as possible (Lines 54 – 59).
    - How to determine custodianship in the absence of an agreement (Lines 65 – 69).
    - Transferring records in a method that allows them to be tracked (Lines 206 – 212).
    - The use of video/smart phone recordings by patients and the implications for medical records (Lines 225 – 235).

B. Key Additions and Revisions: *Medical Records Documentation*

Professional and non-judgmental documentation

- The draft policy included a new expectation that physicians' documentation must be non-judgmental. This expectation has been revised and focuses solely on ensuring documentation is professional and non-discriminatory (Provision #3).

    - Feedback from Council and committee members suggested that what is considered *judgmental* is subjective and making judgments is central to a physician's job.
    - Additional guidance has also been provided in the *Advice* about why this expectation is important and directs physicians to the CMPA's e-training modules for more information on appropriate documentation (Lines 84 – 92).

Documenting on the physician's behalf

- The draft policy required physicians to ensure that the expectations in the policy are met when an entry is made on their behalf. Consultation feedback requested clarity about this provision and whether it applied to trainees, delegates, or others. There was also a question about co-signing entries and whether expectations differ depending on level of training (i.e. trainees, medical scribes, etc.).

- After much consideration, the Working Group felt it would be more appropriate for this issue to be considered in the context of other College policy reviews that are underway (i.e., *Delegation of Controlled Acts, Professional Responsibilities in Undergraduate Medical Education* and *Professional Responsibilities in Postgraduate Medical Education*) and directed that this provision be removed from the draft policy.

Use of Templates

- The expectations pertaining to the use of templates have been revised. In particular, the revised draft clarifies that templates *are* permitted and the requirement prohibiting the use of pre-populated templates, where possible, has been removed.

- Instead, the policy and *Advice* document have both been updated to emphasize that pre-populated templates pose risks to accuracy and the revised draft requires physicians to only use templates that allow patient encounters to be captured accurately and comprehensively (Provision #5).

    - The provisions in the draft policy were being interpreted as a general prohibition on the use of templates and some survey respondents expressed that a prohibition is unreasonable. A few respondents also indicated that documentation requirements contribute to burnout and expressed concern that restrictions on templates would make documentation more onerous.

Clinical Notes

- Consistent with the Subjective Objective Assessment Plan (SOAP) format and details captured in the QA/QI *Self-Guided Chart Review*, additional clinical details are required to be documented, including:

    - presenting complaint;
    - any treatment or therapy provided and the patient's response and outcomes;
    - advice given to patients and/or care givers (Provision #10).

Documenting "hallway consults"

- The draft policy required physicians to use their professional judgement in determining whether to document the details of discussions with other health care professionals involved in the patient's care, considering factors such as whether the discussion informed the care and treatment of the patient.

- Generally, survey respondents agreed that the expectation was reasonable, however, some respondents expressed concern that the requirement would suppress collegiality, learning and collaboration and/or open them up to medico-legal issues. In response to concerns that this provision would have unintended consequences (i.e., hinder collaboration between care providers), the Working Group directed that this provision be removed.

Corrections to Medical Records

- The draft policy set out expectations for correcting medical records that reflect the requirements under *PHIPA*. In response to feedback from the IPC, revisions have been

made to further align the draft with the legislation, including an additional expectation that physicians who make corrections in response to a patient request must notify the patient and others who received the incorrect information, if it is reasonably possible to do so, and it is expected to have an effect on the ongoing provision of health care (Provision #14).

Advice Document

- In response to feedback and requests for additional information, the *Advice* document has been updated to address the following additional issues:

    - Importance of Cumulative Patient Profiles (CPPs) that are up to date and accurate (Lines 160 – 172); and
    - Contemporaneous documentation as a best practice (Lines 197 – 202).

NEXT STEPS:

- Should Council approve the revised draft policies, they will be announced in *Dialogue* and they will replace the current *Medical Records* policy on the College's website.

DECISION FOR COUNCIL:

1. Does Council approve the revised draft *Medical Records Management* and *Medical Records Documentation* as policies of the College?

Contact: Tanya Terzis, ext. 545

Date: February 13, 2020

Attachments:

Appendix A: Revised Draft *Medical Records Management* Policy
Appendix B: Revised Draft *Medical Records Documentation* Policy
Appendix C: Revised Draft *Advice to the Profession: Medical Records Management*
Appendix D: Revised Draft *Advice to the Profession: Medical Records Documentation*

Medical Records Management

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Policy

1. Whether in paper or electronic format, physicians **must** comply with all relevant legislation[1] and regulatory requirements related to medical record-keeping.

Establishing Custodianship and Accountabilities

2. Physicians **must** have a written agreement that establishes custodianship and clear accountabilities regarding medical records if they:

    a. practise in a setting where there are multiple contributors to a record-keeping system (e.g., a group or interdisciplinary practice, settings with a shared electronic medical record (EMR)); or
    b. are not the owner of the practice and/or of the EMR licence.[2,3]

3. Physicians **must** ensure their agreements:

[1] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*); Part V of the General, Ontario Regulation 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act*, General Regulation); General, Ontario Regulation 57/92, enacted under the *Independent Health Facilities Act*, R.S.O.1990, c.1.3 (hereinafter *IHFA,* General Regulation); Hospital Management, Regulation 965, enacted under the *Public Hospitals Act*, R.S.O. 1990, c.P.40 (*Public Hospitals Act,* Hospital Management Regulation); *Personal Information Protection and Electronic Documents Act of Canada*, S.C. 2000, c. 5 (hereinafter *PIPEDA*).

[2] Section 14(1) of the *Public Hospitals Act* sets out that patient medical records compiled in a hospital are the property of the hospital. For the purposes of this policy, the provisions set out in the *Public Hospitals Act*, along with the terms of a physician's hospital privileges can serve as the official agreement for physicians who work in hospitals.

[3] Additional advice for establishing such agreements can be found in the Canadian Medical Protective Association's (CMPA) *Electronic Records Handbook*. In particular, the CMPA's Data Sharing Principles and the template titled *Contractual Provisions for Data Sharing* can be reviewed and serve as a model. The OMA can also provide assistance establishing contracts.

a. are in place prior to the establishment of the group practice, business arrangement, or employment, or as soon as possible afterward;
b. comply with the *Personal Health Information Protection Act, 2004* (*PHIPA*) and with the expectations set out in this policy; and
c. address:
    i. custody and control of medical records, including upon termination of employment or the practice arrangement;
    ii. privacy, security, storage, retention, and destruction of records; and
    iii. enduring access for themselves[4] and their patients.

4. Physicians with custody or control of medical records **must** give all former partners and associates reasonable access to their patient medical records to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation, when necessary.[5]

5. Physicians moving to a new practice who do not have custody or control of the medical records of patients who choose to follow them to the new practice, **must** obtain patient consent to transfer copies of the records to the new location.

6. Physicians **must** take all reasonable steps within their control to prevent a conflict about medical records from compromising patient care.

Access and Transfer of Medical Records

Providing Access to Medical Records

7. Physicians **must** provide patients and authorized parties[6] with access to, or copies of, all the medical records in their custody or control upon request, unless an exception applies.[7,8]

8. Where an exception applies and access is refused, physicians **must** inform the individual in writing of the following:

[4] See *PHIPA*, s. 41(1) for the specific circumstances where physicians are permitted access to the personal health information of their former patients.
[5] See *PHIPA*, s. 41(1) for the specific circumstances where access can be provided to former partners and associates.
[6] Authorized parties include substitute decision-makers and estate trustees/executors of the estate where applicable, and third parties where consent has been obtained.
[7] *PHIPA*, s. 52; Section 52 of *PHIPA* contains a comprehensive list of the exceptions.
[8] There are exceptions that may limit the information a physician is required to produce in the context of an independent medical examination. For more information, please refer to *PIPEDA*. The CMPA's article, *Providing access to independent medical examinations* also sets out advice on this issue.

a. the fact of the refusal;
b. the reason for the refusal; and
c. the right of the patient to make a complaint to the Information and Privacy Commissioner of Ontario (IPC).[9]

9. Physicians **must** provide patients and authorized parties with explanations of any term, code, or abbreviation used in the medical record, upon request.[10]

Transferring Copies of Medical Records

10. Physicians **must** retain original medical records for the time period required by the Regulation[11] (see Medical Records Retention below) and only transfer copies to others.

11. Physicians **must** only transfer copies of medical records where they have consent or are permitted or required by law to do so.[12]

12. Physicians **must** transfer copies of medical records in a timely manner, urgently if necessary, but no later than 30 days after a request.[13] What is timely will depend on whether there is any risk to the patient if there is a delay in transferring the records (e.g., exposure to any adverse clinical outcomes).

13. Physicians **must** transfer copies of the entire medical record, unless providing a summary or a partial copy of the medical record is acceptable to the receiving physician and/or the patient.

14. Physicians **must** transfer copies of medical records in a secure manner[14] and document the date and method of transfer in the medical record.[15]

[9] *PHIPA,* s. 54(1)(c). When access is refused on certain grounds, there are exceptions to the type of information that must be provided to patients. See *PHIPA,* s.54(1.1) for more information.
[10] *PHIPA*, s. 54(1)(a).
[11] *Medicine Act*, General Regulation, s. 19(1).
[12] For more information regarding disclosure, please refer to the College's *Protecting Personal Health Information* policy.
[13] *PHIPA*, s. 54(2). Physicians are required under *PHIPA* to respond to requests of records transfer as soon as possible, but no later than 30 days of the request. Sections 54(3) and 54(5) of *PHIPA* set out provisions for circumstances requiring expedited access and an extension.
[14] *PHIPA,* s. 13(1).
[15] For more information on transferring records, please see the *Advice to the Profession: Medical Records Management* document.

Fees for Copies and Transfer of Medical Records[16]

Fulfilling a request for copying and transferring medical records is an uninsured service. As such, physicians are entitled to charge patients or third parties a fee for obtaining a copy or summary of their medical record.

15. When charging for copying and transferring medical records, physicians **must**:

    a. provide a fee estimate prior to providing copies or summaries;[17]
    b. provide an itemized bill that provides a breakdown of the cost, upon request (e.g., cost per page, cost for transfer, etc.);[18] and
    c. only charge fees that are reasonable.

16. When determining what is reasonable to charge, physicians **must** ensure that fees:

    a. do not exceed the amount of "reasonable cost recovery";[19] and
    b. are commensurate with the nature of the service provided and their professional costs (i.e., reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting individual).[20]

17. When determining a reasonable fee, physicians must consider the recommended fees set out in the Ontario Medical Association's *Physician's Guide to Uninsured Services* ("the OMA Guide")[21,22] and the applicable orders of the IPC[23].

[16] These requirements apply regardless of whether access is provided directly by a physician or an agent of the physician, such as a records storage company.
[17] *PHIPA*, s. 54(10).
[18] It is an act of professional misconduct to fail to provide an itemized invoice when asked (See s. 1(1) paragraph 24 of Ontario Regulation 856/93 *Professional Misconduct*, enacted under the *Medicine Act, 1991* S.O. 1991. C.30 (hereinafter *Professional Misconduct Regulation*).
[19] *PHIPA*, s. 54(11).
[20] In accordance with s. 1(1), paragraph 21 of the *Professional Misconduct Regulation* it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided.
[21] The OMA Guide is typically updated annually, and so physicians must ensure they have reviewed the most recent edition.
[22] While physicians are not obliged to adopt the recommended fees set out in the OMA Guide, in accordance with s. 1(1) paragraph 22 of the *Professional Misconduct Regulation*, it is an act of professional misconduct to charge more than the current recommended fees in the OMA Guide without first notifying the patient of the excess amount that will be charged.
[23] See IPC Orders HO-009 and HO-14.

18. When determining a reasonable fee, physicians **must** additionally consider the patient's ability to pay.[24] In particular, physicians **must** consider the financial burden that these fees might place on the patient and consider whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds.[25]

19. Physicians may request pre-payment for records or take action to collect any fees owed to them but **must not** put a patient's health and safety at risk by delaying the transfer of records until payment has been received.[26]

Retention and Destruction

Medical Records Retention[27]

20. Physicians **must** ensure medical records are retained for a minimum of the following time periods[28]:

    a. *Adult patients:* 10 years from the date of the last entry in the record.
    b. *Patients who are children:* 10 years after the day on which the patient reached or would have reached 18 years of age.[29,30]

[24] The Canadian Medical Association's *Code of Ethics and Professionalism* (#26) states that physicians have an ethical and professional responsibility to "Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees."

[25] For more information on how to determine a patient's ability to pay, please refer to the *Advice to the Profession: Medical Records Management* document.

[26] For additional guidance on fees please refer to the College's *Uninsured Services: Billing and Block Fees* policy.

[27] There are separate provisions for the retention of certain records, including the following:

- Physicians who cease to practise family medicine or primary care have specific retention requirements under s. 19(1)(2) of the *Medicine Act*, General Regulation; see the College's *Closing a Medical Practice* policy for more information.
- Hospitals have separate retention schedules for diagnostic imaging records; see s. 20(4) of the *Public Hospitals Act*, Hospital Management Regulation for more information.
- Independent health facilities have separate retention schedules for patient health records; see s. 11(1) of the *IHFA,* General Regulation for more information.

[28] Retention requirements apply equally to the medical records of patients who are living and deceased.

[29] *Medicine Act,* General Regulation, s. 19(1).

[30] When a request for access to personal health information is made before the retention period ends, physicians are obligated under section 13(2) of *PHIPA* to retain the personal health information for as long as necessary to allow for an individual to take any recourse that is available to them under *PHIPA*. This may require physicians to retain records longer than the above time periods, in some instances. Furthermore, s. 15(2) of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B allows for some legal proceedings to be brought forward 15 years after the act or omission on which the claim is based took place and thus physicians may wish to retain records for longer than the 10 year requirement.

Destruction of Medical Records

21. Physicians **must** only destroy medical records once their obligation to retain the record has come to an end.

22. When destroying medical records, physicians **must** do so in a secure and confidential manner[31] and in such a way that they cannot be reconstructed or retrieved. As such, physicians **must**, where applicable:

    a. cross-shred all paper medical records;
    b. permanently delete electronic records by physically destroying the storage media or overwriting the information stored on the media; and
    c. destroy any back-up copies of records.[32]

Storage and Security

Storage

23. Physicians **must** ensure medical records in their custody or control are stored in a safe and secure environment[33] and in a way that ensures their integrity and confidentiality, including:

    a. taking reasonable steps to protect records from theft, loss and unauthorized access, use or disclosure, including copying, modification or disposal;[34]
    b. keeping all medical records in restricted access areas or in locked filing cabinets to protect against unauthorized access, loss of information and damage;
    c. backing-up electronic records on a routine basis[35] and storing back-up copies in a secure environment separate from where the original data is stored.

24. Where physicians choose to store medical records content that is no longer relevant to a patient's current care separately from the rest of the medical record, physicians **must** include a notation in the record indicating that documents have been removed from the chart and the location where they have been stored.

---

[31] *PHIPA*, s. 13(1).
[32] For further information, see s. 13(1) of *PHIPA* and the IPC's Fact Sheets on *Secure Destruction of Personal Information* and *Disposing of Your Electronic Media*.
[33] *PHIPA*, s. 13(1).
[34] *PHIPA*, s. 12(1). What is reasonable in terms of records management protocols will depend on the threats and risks to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to an identifiable individual.
[35] The CMPA suggests daily or weekly back-ups be considered. The CMPA provides risk management advice regarding back-up and recovery practices for EMR systems in its *Electronic Records Handbook*.

25. Physicians **must** ensure medical records are readily available and producible when access is required.[36]

Security[37]

26. Physicians with custody or control of medical records **must** ensure that:

    a. all individuals who have access to medical records are bound by appropriate confidentiality agreements; and
    b. agreements that address data sharing are established for all health care providers, organizations or service providers who will have access to or who will be sharing patient health information with the physician.[38]

27. Physicians with custody or control of medical records **must** have records management protocols that regulate who may gain access to the medical records in their custody or control and what they may do according to their role, responsibilities, and the authority they have.[39]

28. Accordingly, physicians with custody or control of electronic records **must**:

    a. ensure each authorized user has a unique ID and password; and
    b. maintain an audit trail for all accesses (views) of personal health information, even where no changes are made to the record.

29. When using an electronic record-keeping system, physicians **must** not share their credentials or passwords.

Electronic Records - System Requirements

30. Physicians **must** use due diligence when selecting an EMR system and/or engaging EMR service providers and **must** only use electronic record-keeping systems that:

[36] This includes where physicians rely on an external facility or organization, such as a commercial storage provider, diagnostic facility, or clinic to retain records.
[37] For expectations related to privacy breaches please refer to the College's *Mandatory and Permissive Reporting* policy.
[38] The CMPA's *Electronic Records Handbook* contains advice for creating data sharing agreements.
[39] Records management protocols include both physical and logical access controls. Physical access controls are physical safeguards intended to limit persons from entering or observing areas of the physician's office that contain confidential health information or elements of an EMR system. Logical access controls are system features that limit the information users can access, modifications they can make, and applications they can run. Examples of the latter include the use of "lockboxes" and "masking" options to restrict access to personal health information at a patient's request.

a. comply with privacy standards set out in *PHIPA,*
b. comply with the standards set out in the Regulation[40], and
c. can fulfill the requirements set out in this policy and *the Medical Records Documentation* policy (e.g., capturing all pertinent personal health information).[41]

31. In particular, the Regulation[42] requires that physicians **must** only use electronic systems that:

a. Provide a visual display of the recorded information;
b. Provide a means of access to the record of each patient by the patient's name and Ontario health number, where applicable;
c. Are capable of printing the recorded information promptly;
d. Are capable of visually displaying and printing the recorded information for each patient in chronological order;
e. Include a password or otherwise provide reasonable protection against unauthorized access;
f. Maintain an audit trail (a record of who has accessed the electronic record) that:
    i. records the date and time of each entry of information for each patient,
    ii. indicates any changes in the recorded information,
    iii. preserves the original content of the recorded information when changed or updated, and
    iv. is capable of being printed separately from the recorded information for each patient;
g. Automatically back up files and allow the recovery of backed-up files or otherwise provide reasonable protection against loss of, damage to, and inaccessibility of, information.[43]

32. Physicians **must** be proficient with their electronic record-keeping system in order to:

a. meet the requirements for record-keeping set out in relevant legislation and this policy; and
b. participate in all regulatory processes (e.g., College investigations and assessments).

[40] *Medicine Act*, General Regulation, s. 20.
[41] Use of EMRs that are certified by OntarioMD can help ensure compliance with this expectation. Please see the *Advice to the Profession: Medical Records Management* document for more information on the benefits of using EMRs that are certified by OntarioMD.
[42] *Medicine Act*, General Regulation, s. 20.
[43] *Medicine Act*, General Regulation, s. 20.

Transitioning Records Management Systems[44]

33. When transitioning from one record-keeping system to another (i.e., a paper-based to electronic system, or from one electronic system to another), physicians **must**:

    a. maintain continuity and quality of patient care;
    b. continue appropriate record-keeping practices without interruption;
    c. protect the privacy of patients' personal health information; and
    d. maintain the integrity of the data in the medical record.

34. To ensure the integrity of the medical record is maintained, physicians who are transitioning from one record-keeping system to another **must** have a quality assurance process in place that includes:

    a. written procedures that are consistently followed; and
    b. verification that the entire medical record has remained intact upon conversion (e.g., comparing scanned copies to originals to ensure that they have been properly scanned or converted).

35. Physicians who wish to destroy original paper medical records following conversion into a digital format **must**:

    a. use appropriate safeguards to ensure reliability of digital copies;
    b. save scanned copies in "read-only" format; and
    c. destroy medical records in accordance with the expectations set out in this policy.

36. Physicians who use voice recognition software or Optical Character Recognition (OCR) technology to convert records into searchable, editable files **must** retain either the original record or a scanned copy for the retention periods set out above.

37. So that complete and up to date information is contained in one central location, physicians with custody or control of records **must:**

    a. set a date whereby the new (electronic) system becomes the official record; and

[44] For additional guidance related to transitioning record-keeping systems please refer to the companion *Advice to the Profession: Medical Records Management* document.

b. inform all health care professionals who would reasonably be expected to contribute or rely on the record of this date.

38. Physicians **must** only document in the new system from the official date onward.

Appendix B

Medical Records Documentation

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Cumulative Patient Profile (CPP) or equivalent patient health summary: A summary of essential information about a patient that includes critical elements of the patient's medical history and allows the treating physician, and other health care professionals using the medical record, to quickly get a picture of the patient's overall health.

Policy

1. Physicians **must** comply with all relevant legislation[1] and regulatory requirements related to medical record-keeping[2].

Principles for Documenting the Patient Encounter

2. The goal of the medical record is to "tell the story" of the patient's health care journey. As such, physicians' documentation in the medical record **must** be:

    a. legible;[3]
    b. understandable to health care professionals reading the record, including avoiding the use of abbreviations that are known to have more than one meaning in a clinical setting or that are not commonly used or understood;

[1] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*); Part V of the General, Ontario Regulation 114/94, enacted under *the Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act*, General Regulation); General, Ontario Regulation 57/92, enacted under the *Independent Health Facilities Act*, R.S.O.1990, c.1.3 (hereinafter *IHFA,* General Regulation); Hospital Management, Regulation 965 enacted under the *Public Hospitals Act*, R.S.O. 1990, c.P.40 (hereinafter *Public Hospitals Act*, Hospital Management Regulation); *Health Insurance Act*, R.S.O.1990, c. H.6 (hereinafter *Health Insurance Act*).

[2] Additional expectations for record-keeping are set out in other College policies, including Medical Records Management, Transitions in Care, Closing a Medical Practice, Protecting Personal Health Information, Managing Tests, Consent to Treatment, and Prescribing Drugs.

[3] *Medicine Act,* General Regulation, s. 18(3).

c. accurate;[4]
d. complete and comprehensive, containing:
    i. all relevant information;
    ii. information that conveys the patient's health status and concerns;
    iii. any pertinent details that may be useful to the physician or future health care professionals who may see the patient or review the medical record; and
    iv. documentation that supports the treatment or procedure provided (i.e., rationale for the treatment or procedure is evident in the record);
e. unique to each patient encounter (e.g., refraining from inappropriate use of copy and paste);
f. identifiable, containing a signature or audit trail that identifies the author;
g. written in either English or French; and
h. organized in a chronological and systematic manner[5].

3. Physicians **must** ensure their documentation in the medical record is professional and non-discriminatory, and in accordance with the College's *Professional Obligations and Human Rights* policy.[6]

Timing of Documentation

4. To support the safe delivery of care, physicians **must** document their patient encounters as soon as possible.[7,8]

Use of Templates

5. The use of electronic record templates, particularly those with pre-populated fields, poses risks to accurate and complete medical records. In keeping with the requirements of accuracy and completeness set out in 2(c) and 2(d) above, physicians who use templates **must**:

[4] There are circumstances where a physician's records are transcribed on the physician's behalf. In these circumstances the notation "dictated but not read" is often used to signify that that the physician has not yet reviewed the transcription for accuracy. The Canadian Medical Protective Association's article *"Dictated but not read": Unreviewed clinical record entries may pose risks* sets out advice on how to mitigate risks when dictating medical record entries or reports.
[5] Section 18(3)(b) of *Medicine Act*, General Regulation requires records to be kept in a systematic manner.
[6] Additional guidance related to appropriate documentation is set out in the *Advice to the Profession: Medical Records Documentation* document.
[7] Section 17.4 (5) of the *Health Insurance Act* requires records to be prepared promptly when the service is provided. Additional guidance on best practices for documentation completion is set out in the *Advice to the Profession: Medical Records Documentation* document.
[8] Some components of the medical record have specific requirements for completion. Please see the College's *Transitions in Care* policy for expectations related to completing and distributing discharge summaries and consultation reports.

a. only use templates that allow patient encounters to be captured accurately and comprehensively (e.g., templates that allow entry of free-text or that can be customized to allow for greater descriptive detail); and
b. verify that the entries populated using a template accurately reflect each patient encounter and that all pertinent details about the patient's health status have been captured.[9]

What to Document: Medical Records Content

6. Physicians **must** ensure that patient identification (i.e., name, date of birth, OHIP number, gender information) and contact information (i.e., telephone number and address) are captured in all medical records.[10]

7. Physicians **must** date each entry in the medical record. Where the date of the patient encounter differs from the date of documentation, physicians **must** record both dates.[11]

CPP or Equivalent Patient Health Summary

8. Primary care physicians **must** include an easily accessible, accurate, and up to date CPP, or an equivalent patient health summary, in each patient medical record, which includes the following, where applicable:

    a. patient identification;
    b. patient contact information;
    c. personal and family data (e.g., occupation, life events, habits, family medical history);
    d. past medical history (e.g., past serious illnesses, operations, accidents, genetic history);
    e. risk factors;
    f. allergies and drug reactions;
    g. ongoing health conditions (e.g., problems, diagnoses, date of onset);
    h. health maintenance (e.g., periodic health exams, immunizations, disease surveillance);
    i. names of any consultants involved in the patient's care;
    j. long-term management needs (e.g., current medication, dosage, frequency);
    k. major investigations;

[9] For additional guidance related to templates please refer to the *Advice to the Profession: Medical Records Documentation* document.
[10] Section 18(1) paragraphs 1 and 2 of the *Medicine Act,* General Regulation require physicians to make records for each patient containing the patient's name, address, date of birth and Ontario health number, where applicable.
[11] Documenting the date of the professional encounter is a requirement under s.18 of the *Medicine Act,* General Regulation; s. 19(2) of the *Public Hospitals Act,* Hospital Management Regulation requires each entry in a medical record to indicate the date on which it was made.

l. date the CPP was last updated; and
m. contact person in case of emergencies.

9. All other physicians **must** use their professional judgement to determine whether to include a CPP or an equivalent patient health summary in each patient medical record, considering a variety of factors, such as the nature of the physician-patient relationship (e.g., whether it is a sustained physician-patient relationship[12]), the nature of the care being provided, and whether the CPP or equivalent summary would reasonably contribute to quality care.[13]

Clinical Notes

10. Physicians **must** document the following for all patient encounters, where indicated:

a. presenting complaint;
b. a focused relevant history;
c. an assessment and an appropriate focused examination;
d. a diagnosis and/or differential diagnosis;
e. any treatment or therapy provided and the patient's response and outcomes; and
f. a management and follow-up plan, including advice given to patients and/or care givers.

11. Physicians **must** capture details of the following in each patient medical record:

a. any prescriptions issued in accordance with the College's *Prescribing Drugs* policy;
b. consent in accordance with the College's *Consent to Treatment* policy and any consent to treatment obtained in writing;
c. all tests requisitioned and referrals made[14], including a copy of the referral note, and any associated reports and results (e.g., laboratory, diagnostic, pathology);[15]
d. any treatments, investigations, or referrals that have been declined or deferred, the reason, if any, given by the patient, and discussion of the risks;
e. any operative and procedural records;[16] and

[12] A sustained physician-patient relationship is physician-patient relationship where care is actively managed over multiple encounters.
[13] There may be variations in content and format of the CPP or equivalent patient health summary based on the physician's practice area and the nature of the physician-patient relationship (i.e., whether there is a sustained physician-patient relationship).
[14] For a consultation, s.18 (1) of the *Medicine Act*, General Regulation requires medical records to contain indication of the name and address of the primary care physician and of any health professional who referred the patient.
[15] For additional guidance regarding information that must be contained in a referral note and consultation report, please refer to the College's *Transitions in Care* policy.
[16] Guidance for documenting operative and procedural notes is set out in the *Advice to the Profession: Medical Records Documentation* document.

f. any discharge summaries.[17]

Telephone and Electronic Communications with Patients

12. Physicians **must** capture in the medical record (e.g., document or upload, where relevant) details of all communication with patients related to clinical care that occur via telephone, or other digital means (e.g., e-mail,[18] patient portals or other digital platforms), including the mode of communication.

Corrections to Medical Records

13. Where it is necessary to correct an inaccurate or incomplete medical record physicians **must:**

    a. date and initial the additions or changes and either:
        i. maintain the incorrect information in the record, clearly label it as incorrect, and ensure the information remains legible (e.g., by striking through incorrect information with a single line); or
        ii. remove and store the incorrect information separately and ensure there is a notation in the record that allows for the incorrect information to be traced;[19,20] and
    b. consider whether to notify any health care providers involved in the patient's care, considering factors such as whether the correction would have an impact on treatment decisions.

14. In accordance with the *Personal Health Information Protection Act, 2004*, physicians who make a correction in response to a patient request **must:**

    a. inform the patient of the correction made, and
    b. at the request of the patient, inform in writing those who have received the incorrect information, if:
        i. it is reasonably possible to do so, and

[17] Sections 19(4) and 19(5) of the *Public Hospitals Act*, Hospital Management Regulation set out a number of additional requirements for documentation in a hospital setting. Physicians who practise in hospitals are advised to refer to the regulation for information about the specific requirements.

[18] For expectations related to e-mail communications with patients please refer to the College's *Protecting Personal Health Information* policy.

[19] These requirements are reflective of *PHIPA,* s. 55(10).

[20] With an electronic record, this can be achieved by using a digital strikeout (e.g., "track changes") or where this is not possible, an addendum explaining the necessary changes.

ii. the correction is reasonably expected to have an effect on the ongoing provision of health care or provide other benefits to the patient.[21]

15. If the physician is of the opinion that a requested correction is unwarranted (i.e., patient has not demonstrated to their satisfaction that the record is incomplete or inaccurate), the physician **must:**

a. give the reasons for the refusal, and
b. inform the patient that they are entitled to:
    i. prepare a statement of disagreement that sets out the correction;
    ii. attach the statement of disagreement to the medical record and disclose the statement of disagreement whenever information related to the statement is disclosed;
    iii. require the physician to make reasonable efforts to disclose the statement to anyone who the physician would have notified had the physician made the correction (see provision 14 above); and
    iv. make a complaint to the Information and Privacy Commissioner of Ontario.[22]

[21] *PHIPA*, s. 55 (10).
[22] *PHIPA*, s. 55(11). For additional requirements pertaining to corrections, please refer to s. 55 of *PHIPA*.

Advice to the Profession: Medical Records Management

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The healthcare system is transforming as a result of the development and adoption of new digital health tools. With respect to medical record-keeping, the widespread adoption of electronic medical records (EMRs) has particularly changed the way that medical records are used and managed. Navigating the responsibilities regarding medical records can be a complex and daunting task for physicians, particularly in this era of digital health where there may be questions about ownership and accountabilities. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the *Medical Records Management* policy and provide guidance around how these expectations may be effectively discharged. This *Advice* is also intended to help physicians navigate their roles and responsibilities and provide links to resources on best practices.

Roles and Obligations Regarding Medical Records

The Medical Records Management policy sets out expectations for physicians with custody or control of their records (i.e., the custodian of the records) and expectations for physicians more broadly (all physicians). Aren't physicians always the custodians of their patient medical records? How do I determine what my role and responsibilities are regarding medical records?

Physicians are not always the custodians of their patient medical records. Physicians will either be the "custodian" of their medical records or an "agent" of the custodian. These roles and their corresponding obligations are set out in the *Personal Health Information Protection Act, 2004* (*PHIPA)*.

A "health information custodian" ("custodian") is a person or organization who, as a result of their power, duties, or work, has custody or control of personal health information (PHI).[1] This includes health care organizations such as hospitals, pharmacies, and laboratories, as well as some individual physicians (such as owners of a clinic or physicians working as a sole practitioner in their own practice).[2]

[1] "Health information custodian" is defined at s. 3(1) of the *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*).

[2] This list is non-exhaustive; a full legislative definition, along with certain exceptions, is found s. 3 of *PHIPA.*

An "agent" refers to individuals granted permission by a custodian to act on their behalf and handle personal health information, as required by their duties.[3] Physicians working as employees in clinics or practising in hospitals are examples of physicians who may be acting as agents. In these scenarios the custodian might be the hospital, clinic, or owner of a clinic, including someone who is not a health care professional.

Roles, responsibilities and rights of access to medical records are generally determined by *PHIPA*, a physician's status as custodian or agent, and the agreements physicians enter into upon employment or establishment of a practice or practice arrangement.

Under *PHIPA*, those who have custody or control of medical records have ultimate responsibility for ensuring records are maintained in accordance with legal requirements. However, physicians who do not have custody or control of their patient medical records also have legal, ethical and professional obligations regarding records.

Physicians who practise in settings where there are multiple contributors to a record-keeping system or who are not the owner of the practice and/or of the EMR licence are required to have written agreements that address custodianship. Why is this necessary?

The move away from a sole practitioner model of care and increased use of electronic records has led to ambiguity about physicians' roles and responsibilities regarding medical records, particularly where there is a shared EMR system or where the physician is not the owner of the clinic and/or the EMR licence. Questions or conflicts related to ownership and rights of access often arise when a physician leaves a practice and there is no written agreement about records. Written agreements help to minimize conflicts, clarify rights and responsibilities, and to ensure compliance with medical records obligations. This in turn promotes quality care.[4]

With this in mind, the policy requires physicians to have agreements in place *prior to* the establishment of a group practice, business arrangement, or employment, or *as soon as possible afterward*. Physicians who do not currently have written agreements that explicitly addresses custodianship must establish them as soon as possible. Reviewing existing agreements is also worthwhile and can help ensure compliance with the policy and applicable legislation.

[3] "Agent" is defined at s. 2 of *PHIPA.*

[4] The Canadian Medical Protective Association's (CMPA) *Electronic Records Handbook* has advice for establishing such agreements. In particular, the CMPA's Data Sharing Principles and the template titled Contractual Provisions for Data Sharing contained within can be reviewed and serve as a model. The OMA can also provide assistance establishing agreements.

Patient medical records compiled in a hospital are the property of the hospital.[5] For the purposes of this policy, the provisions set out in the *Public Hospitals Act*, along with the terms of a physician's hospital privileges can serve as the official agreement for physicians who work in hospitals.

How do I determine who the custodian of my records is if I do not currently have a written agreement?

Determining custodianship in the absence of a written agreement can be difficult as it can depend on a number of factors and is ultimately case-specific. Where there are disputes about custodianship physicians can consult the CMPA or obtain independent legal counsel.

What if I am concerned that the custodian of my patient medical records is not acting in accordance with applicable legislation and the expectations of the Medical Records Management policy?

Physicians who are not the custodians of their patient medical records may feel they have limited control over the record-keeping system or procedures where they practise. Where physicians are concerned that the facility's record-keeping practices do not meet the requirements of the *Medical Records Management* policy, or there are disputes about records, the Canadian Medical Protective Association (CMPA) can provide legal advice. As required by the *Medical Records Management* policy, physicians must do everything reasonably within their control to prevent disputes about records from impacting patient care. Written agreements regarding medical records can provide assurance that the expectations of the policy are being met.

Transitioning to an (other) electronic record-keeping system

What are some considerations when deciding which EMR vendor to choose?

Choosing an EMR vendor is a crucial step in the process of transitioning to electronic records and warrants careful attention and due diligence. Physicians are not necessarily experts in technology and may need assistance in evaluating and choosing the appropriate vendor. OntarioMD can help physicians determine the appropriate system for their practice needs.

EMR systems vary in terms of capabilities, space requirements to accommodate hardware, data storage capacity, and degree of control over the data within the EMR and the functions it can perform. When making a choice about an EMR, it is important to consider the type of system that best meets a physician's unique practice needs, including the following:

[5] Section 14(1) of the *Public Hospitals Act*, R.S.O. 1990, c.P.40.

- requirements set out in policy and legislation (whether vendor policies are compliant with regulations under the *Medicine Act, 1991*[6] and *PHIPA),*
- privacy and security functions of the software,
- objectives they hope to achieve with an EMR,
- the functions they require within their EMR,
- advice from colleagues or experienced EMR users about the advantages and disadvantages of particular systems,
- the support and training offered by the EMR vendor,
- the stability of the company to provide continued support for the foreseeable future, and
- vendor policies about software upgrades and data access provisions in case of a departure from a physician group.

It is important for physicians to seek legal review of contracts with EMR vendors prior to entering into any agreements.

What are some resources to help me transition to an (other) EMR system?

Transitioning to an EMR, or to a *new* EMR, can be a daunting, time consuming, and expensive process for physicians but is ultimately intended to enhance the physician's practice. Physicians seeking additional guidance related to transitioning systems can refer to the following resources for assistance:

1) Information and Privacy Commissioner of Ontario's (IPC's) *A Practical Tool for Physicians Transitioning from Paper-Based Records to Electronic Health Records*
2) CMPA's *Electronic Records Handbook*
3) OntarioMD's *EMR Data Migration Guide for Community Care Practices*
4) OntarioMD's *Transition Support Guide*

Using Certified EMRs

How can I determine which EMRs are compliant with privacy legislation and the standards set out in the Regulation?

Independently verifying that an unaccredited system meets privacy and security standards is difficult. Physicians may not be experts in information technology or security and thus they may rely on service providers to ensure their EMRs are secure. Organizations like OntarioMD can help physicians navigate their choices and support compliance with the policy. Use of EMRs

[6] Ontario Regulation 114/94, General, Section 20, made under the *Medicine Act, 1991*, S.O. 1991, c.30 (hereinafter *Medicine Act*, General Regulation).

that are certified by OntarioMD can help physicians ensure their systems meet privacy and security standards that they would otherwise have to verify independently. Systems that are certified by OntarioMD also provide access to provincial digital tools such as Ontario Laboratories Information System (OLIS), Health Report Manager (HRM), and eConsult.

Maintaining Privacy and Security Standards

I am required to maintain privacy and security standards. Are there resources to help me navigate my obligations? What are some best practices when it comes to ensuring security of medical records?

Guidance released by the IPC, and orders of the IPC can help physicians remain up to date about evolving industry standards.[7]

Additionally, conducting routine privacy assessments, or audits of all processes related to their medical record-keeping practices can help physicians maintain an understanding of the privacy risks of their practice. The CMPA suggests that completing this process is especially prudent when transitioning medical record-keeping systems as it can help physicians identify and minimize the risks associated with the implementation, or change, of an EMR system. For guidance on how to conduct a privacy assessment, physicians can consult the IPC's *Planning for Success: Privacy Impact Assessment Guide*.

Lastly, when using an EMR, the IPC recommends reviewing the audit trail on a regular basis to detect and deter unauthorized access. For more information, please refer to the IPC's guidance document *Detecting and Deterring Unauthorized Access to Personal Health Information*.

Is it appropriate to stay logged into an EMR?

No. Physicians are required by the *Medical Records Management* policy to ensure their electronic record-keeping systems are equipped with user identification and passwords for logging on and are prohibited from sharing their credentials or passwords. Physicians are also required by the *Medical Records Documentation* policy to have identifiable entries. As such, physicians are reminded of the importance of logging out after they are finished documenting in an electronic medical records system.

[7] Guidance documents and orders of the IPC can be found on the Commission's website at www.ipc.on.ca.

The College requires that I be proficient with my electronic record-keeping system but I have just switched from paper records to an EMR and am still learning how to use my new system. Are there resources that can assist me in gaining proficiency?

The College recognizes that becoming skilled with a new system may depend on a number of factors and that it may take some physicians longer than others to do so. There are resources that can assist physicians in gaining proficiency with their systems. For example, OntarioMD's Peer Leader program provides consulting services that can help physicians become more proficient with their EMR, optimize their existing EMR functions, and improve clinical decision support. More information on the Peer Leader program can be found on OntarioMD's website.

Use of Commercial Services

What are my responsibilities when I engage commercial services to assist with managing my patient medical records?

Physicians who are the custodians of their medical records are ultimately responsible for ensuring that medical records are stored and maintained according to legal requirements and the expectations set out in the *Medical Records Management* policy. The same standards apply when physicians engage commercial providers for services such as storage, maintenance, scanning, destruction, and other medical record-keeping related tasks. As such, it is generally good practice to:

- Make any agreements with such providers in writing;
- Ensure agreements reflect the same legal and regulatory requirements that apply to physicians who have custody or control of records;
- Seek legal counsel or contact the CMPA for advice in these circumstances.

Fees and Transferring Medical Records

Am I allowed to charge patients or third parties requesting copies of records for a review of records prior to transfer?

Orders of the IPC set out that a reasonable fee for copying and transferring medical records includes fifteen minutes of review prior to transfer.[8] Some situations may require more than fifteen minutes of review (e.g., if the nature of the request requires careful consideration of sensitive information), however, where the expectations of the *Medical Records Documentation* policy are met, an extensive review (e.g., beyond 15 minutes) would rarely be

[8] See IPC Orders HO-009 and HO-14.

necessary. It would be inappropriate for physicians to charge for a review of records to ensure their records are complete, up to date, and accurate, as this is already a requirement.

In keeping with the requirements in the *Medical Records Management* policy, if charging for a review of records prior to transfer, fees must be reasonable and reflect the nature and reason for the review.

How can physicians assess a patient's ability to pay? How do I know if my patient cannot afford to pay for a copy of their records?

In keeping with the expectations in the College's *Uninsured Services: Billing and Block Fees* policy and the Canadian Medical Association's *Code of Ethics and Professionalism*[9], physicians are required by the *Medical Records Management* policy to consider the patient's ability to pay when setting out reasonable fees for a copy of the patient's medical record. This does not mean that physicians are required to provide this (uninsured) service for free. Rather, the policy requires physicians to give consideration as to whether it would be appropriate to reduce, waive, or allow for flexibility based on compassionate grounds. Whether it is appropriate to adjust fees on compassionate grounds will depend on a variety of factors, including the specific financial circumstances of the patient.

In some practice settings, physicians may naturally become aware of information relevant to a patient's ability to pay during the course of the physician-patient relationship (e.g., health status, challenges faced, etc.). The social determinants of health can be indicators of a patient's ability to pay and help physicians in determining whether it is appropriate to reduce, waive, or allow for flexibility based on compassionate grounds. Patients might also self-identify as being in financial need by expressing concern about their ability to pay the fee for a copy of their medical record. The policy recognizes that physicians are entitled to charge for copying and transferring medical records but aims to strike a balance between this entitlement and the reality that some patients will have real difficulty paying for copies of their records.

What is the best way to send patient medical records to requesting patients or authorized third parties? How can I ensure the secure transfer of records?

Physicians are required by the *Medical Records Management* policy and by *PHIPA* to transfer copies of records in a secure manner. The College is aware of instances where records have been lost during transfer. In such circumstances, physicians have reporting obligations under

[9] The Canadian Medical Association's *Code of Ethics and Professionalism* (#26) states that physicians have an ethical and professional responsibility to "Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees."

PHIPA.[10] Sending records in a method that allows them to be tracked or traced can help to avoid such scenarios.

Medical Records Retention

What are some additional considerations for determining how long to maintain my patient medical records?

A provision in the *Limitations Act*, *2002* allows for some legal proceedings against physicians to be brought forward 15 years after the act or omission on which the claim is based took place.[11] As a result, notwithstanding the 10 year retention requirement set out in regulation[12] physicians may wish to maintain medical records for a minimum of 15 years from the date of the last entry in the record. This would enable physicians to provide evidence should it be required in any future legal proceedings brought against them.

The CMPA provides assistance to physicians who are considering whether to destroy medical records.

Recordings

What should I do if my patient requests to record their appointment? Do I have obligations related to medical record-keeping if a recording is made?

It is becoming increasingly common for patients to want to record their medical appointments via audio, video, or photography. In many cases, these recordings can benefit patients by helping them understand and remember the information they are being provided. However, recordings also have the potential to raise broader issues, including implications for medical records.

The CMPA sets out guidance for responding to patient requests regarding audio and video recordings and advises that where recordings are made, the fact of the recording should be documented in the patient's medical record. For further information, see the CMPA's document *Smartphone recordings by patients: Be prepared, it's happening*.

[10] Please see the College's *Mandatory and Permissive Reporting* and *Protecting Personal Health Information* policies for more information.

[11] Section 15(2) of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B.

[12] Section 19(1) of the *Medicine Act*, General Regulation requires medical records to be retained for a minimum of 10 years from the date of the last entry in the record for adult patients and 10 years after the day on which the patient reached or would have reached 18 years of age, for patients who are children.

Appendix D

Advice to the Profession: Medical Records Documentation

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

The importance of good medical record-keeping

The medical record is a tool that supports each encounter patients have with the health professionals involved in their care. It allows physicians to track their patients' medical history and identify problems or patterns that may help determine the course of health care. The goal of the medical record is to "tell the story" of the patient's health care journey. Medical records can take the form of a paper or electronic record.

Medical records serve many roles in health care. Not only does good medical record-keeping contribute to quality patient care and continuity of care but medical records can also serve a number of other purposes. For instance:

- Optimizing the use of resources, (e.g., by reducing duplication of services);
- Providing essential information for a wide variety of purposes, including:
    - billing,
    - research,
    - investigations (by the Coroner's Office, or the College),
    - legal proceedings,
    - insurance claims; and
- Serving as a valuable tool for self-assessment by allowing physicians to reflect on and assess the care they have provided to patients (i.e., through patterns of care recorded in the EMR).

This document is a companion document to the College's *Medical Records Documentation* policy and provides guidance with respect to how to satisfy the expectations set out in the policy as well as best practices for documenting specific patient encounters.

Subjective Objective Assessment Plan (SOAP)

What method is recommended for documenting patient encounters?

One of the most widely recommended methods for documenting a patient encounter is the Subjective Objective Assessment Plan (SOAP) format. The SOAP format is a structured method for documenting the patient encounter. While other documentation methods are acceptable,

using this format can help ensure the obligations set out in the *Medical Records Documentation* policy are satisfied. Considerations for aspects of care that would be captured by each element of SOAP are set out below.

Subjective Data: The subjective elements of the patient encounter are those which are expressed by the patient (e.g., patient reports of nausea, pain, tingling). This includes the following, where applicable:

- Presenting complaint and associated functional inquiry, including the severity and duration of symptoms;
- Whether this is a new concern or an ongoing/recurring problem;
- Changes in the patient's progress or health status since the last visit;
- Review of medications, if appropriate;
- Review of allergies, if applicable;
- Past medical history of the patient and their family, where relevant to the presenting problem;
- Patient risk factors, if appropriate;
- Salient negative responses.

Objective Data: Objective data are the measurable elements of the patient encounter and any relevant physical findings from the patient exam or tests previously conducted are documented in this section. This includes the following, where applicable:

- Physical examination appropriate to the presenting complaint;
- Positive physical findings;
- Significant negative physical findings as they relate to the problem;
- Relevant vital signs;
- Review of consultation reports, if available;
- Review of laboratory and procedure results, if available.

Assessment: The assessment is the physician's impression of the patient's health issue. This includes the following, where applicable:

- Diagnosis and/or differential diagnosis.

Plan: The physician's plan for managing the patient's condition includes the following, where applicable:

- Discussion of management options;

- Details of consent, in accordance with the College's *Consent to Treatment* policy;
- Tests or procedures ordered and explanation of significant complications, if relevant;
- Consultation requests including the reason for the referral, if relevant;
- New medications ordered and/or prescription repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;
- Any other patient advice or patient education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the patient, including any decision by the patient not to follow the physician's recommendations.

Principles for Documenting the Patient Encounter

Why is it important for documentation in the medical record to be professional?

Medical records are more accessible (e.g., patient portals) and enduring (e.g., digital) than ever before, reinforcing the importance of having clinical notes that are professional and do not contain discriminatory or inappropriate remarks about patients. Physicians are reminded that patients can, and often do, obtain copies of their medical records and clinical notes containing unprofessional comments can undermine the physician-patient relationship. The CMPA's e-learning modules on documentation emphasize the importance of appropriate documentation and can serve as a helpful resource for physicians looking for examples of appropriate documentation.

Record-keeping for Specific Types of Encounters

The expectations set out in the *Medical Records Documentation* policy apply to all physicians, however the College recognizes that a physician's practice area and the nature of the physician-patient relationship (e.g., whether it is a sustained relationship) will influence the type of records and documentation maintained by each physician. As required by the *Medical Records Documentation* policy, documentation in a medical record must always support the treatment or procedure that takes place. General advice for documenting operative and procedural notes is set out below.

What information is typically captured in an operative note?

In general, a typical operative note will include the following:

- Name of the patient and the appropriate identifiers such as birth date, OHIP number, address, and hospital identification number if applicable;

- Name of the family physician (and referring health professional if different from the family physician);
- Operative procedure performed;
- Date and time on which the procedure took place;
- Name of the primary surgeon and assistants;
- Name of the anaesthetist (if applicable) and type of anaesthetic used (general, local, sedation);
- Pre-operative and post-operative diagnoses (if applicable); and
- A detailed outline of the procedure performed, including:
    - administration of any medications or antibiotics,
    - patient positioning,
    - intra-operative findings,
    - prostheses or drains left in at the close of the case,
    - complications including blood loss or need for blood transfusion,
    - review of sponge and instrument count (i.e., a statement of its correctness at the conclusion of the case), and
    - patient status at the conclusion of the case (stable and sent to recovery room vs. remained intubated and transferred to ICU).
- Any required follow-up.

What information is typically captured in a diagnostic or interventional procedural note?

In general, a typical diagnostic or interventional procedural note will include the following:

- Name of the patient and the appropriate identifiers such as birth date, OHIP number, address, and hospital identification number if applicable;
- Name of the family physician (and referring health professional if different from the family physician);
- Procedure performed;
- Details of consent, in accordance with the College's *Consent to Treatment* policy
- Date and time on which the procedure took place;
- Name of the physician performing the procedure and assistants if applicable;
- Name of the anaesthetist if applicable and type of anaesthetic used (general, local, sedation); and
- A detailed outline of the procedure performed including:
    - administration of any medications,
    - complications,
    - findings, and

- recommendations based on the findings if applicable; and
- Any required follow-up.

Physicians are required by the *Medical Records Documentation* policy to document their patient encounters as soon as possible. In keeping with this requirement, it is important to dictate or transcribe operative and procedural notes on the day on which the procedure took place, or where this is not feasible, as soon as possible after the procedure.

Tools and Best Practices for Documenting in the Medical Record

What are best practices for documenting chronic conditions? Are there tools that can help me with this documentation?

Flow sheets are a record-keeping tool that can assist physicians in documenting and tracking important clinical information over time. They are often used to track chronic conditions and deal only with one disease (e.g., diabetes mellitus). There are a number of benefits to the use of flow sheets and thus their use is considered a best practice for treating patients with chronic conditions. Flow sheets permit physicians to easily see trends, which enhances their ability to identify the appropriate treatment, easily retrieve information, and support continuity of care.

Why is it important for Cumulative Patient Profiles (CPPs) to be up-to date and accurate?

A CPP is a summary of essential information about a patient that includes critical elements of the patient's medical history and allows the treating physician, and other health care professionals using the medical record, to quickly get a picture of the patient's overall health. The CPP is a tool that serves to facilitate quality patient care and for this to be achieved, individuals that rely on this information must be able to have confidence that the information within is accurate and current.

In order to comply with the *Medical Records Documentation* policy's expectation of maintaining an easily accessible, up to date, and accurate CPP it is important to review the information in the CPP at each visit and revise the information as it becomes outdated. Regular review and revision is particularly important where other members of a health care team are relying on the information or where physicians are sending the information to third parties such as medical consultants, lawyers, and insurance companies.

If I work in a walk-in clinic, do I need to maintain a CPP for each patient?

The *Medical Records Documentation* policy requires primary care physicians to include a CPP or an equivalent patient health summary in each patient medical record and requires all other physicians to use their professional judgement to determine whether to include one. The policy

sets out considerations for determining whether a CPP is required. For example, the nature of the physician-patient relationship (e.g., whether it is a sustained physician-patient relationship), the nature of the care being provided, and whether the CPP or an equivalent summary would reasonably contribute to quality care.

Physicians who practise in walk-in clinics will need to evaluate whether a CPP is required for a given patient. For example, the more often or more complex care that is being provided, the more likely a CPP would be necessary to facilitate quality care.

What are the risks of using (pre-populated) templates in an EMR and how can I mitigate those risks?

The increased use of electronic records has brought about new challenges related to maintaining accurate and complete records. Through its regulatory activities the College has seen medical records that do not reflect the patient encounter. This can result from the use of pre-populated templates (e.g., templates that auto-populate information in the record). Avoiding the use of pre-populated templates, where possible, can help ensure medical records are accurate. Where pre-populated templates cannot be avoided, carefully reviewing records to ensure accuracy and completeness becomes even more important and removing any information that does not reflect the patient or their experience is vital. Inaccurate information that remains in the record can ultimately pose risks to patients, particularly if it is relied upon by other health care providers.

What are best practices for ensuring that documentation is accurate and comprehensive and meets the expectations of the Medical Records Documentation policy?

The *Medical Records Documentation* policy requires physicians to document the patient encounter as soon as possible. Documenting contemporaneously with the patient encounter promotes accuracy and completeness. The longer the delay between the patient encounter and documentation in the medical record the less reliable the record.

Council Motion

Motion Title: Protecting Personal Health Information Policy

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy “Protecting Personal Health Information”, formerly titled “Confidentiality of Personal Health Information” (a copy of which forms Appendix “ ” to the minutes of this meeting).

CPSO

Council Briefing Note

March 2020

TOPIC: *Protecting Personal Health Information* – Revised Draft Policy for Final Approval

FOR DECISION

ISSUE:

- The College's *Confidentiality of Personal Health Information* policy is currently under review. In September 2019, Council released a draft policy, retitled *Protecting Personal Health Information*, for external consultation. The draft policy has been revised in light of the feedback received through this engagement activity.

- Council is provided with an overview of the changes and is asked whether the revised draft policy can be approved as a policy of the College.

BACKGROUND:

- The current *Confidentiality of Personal Health Information* policy was approved by Council in 2005. A Working Group was struck to undertake the current policy review, consisting of Jerry Rosenblum (Chair), John Langs, and Patrick Safieh, with support from Michael Szul (Medical Advisor) and Marcia Cooper (Legal Counsel).

- Following extensive research[1] and two preliminary consultations (in 2013[2] and 2017[3]), a draft *Protecting Personal Health Information* policy was developed and approved for

---

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and international medical regulatory authorities; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee; and feedback on the current policy from the College's Public and Physician Advisory Service.

[2] 14 responses were received via email, the online discussion page, and regular mail (including 1 from a physician, 2 from non-physicians, and 11 from organizations).

[3] 121 responses were received (15 through the online discussion page, including 2 organizational submissions, and 106 via the online survey). An overview of the feedback was provided to Council in September 2017 as part of the Policy Report.

external consultation by Council in September 2019. The accompanying *Advice to the Profession* document was also released at this time.

- 35 responses were received as part of this engagement.[4] Broadly speaking, stakeholders expressed support for the expanded scope of draft policy, which includes concepts both privacy and confidentiality, and agreed that the draft covered the major topics and areas of concern dealing with protection of PHI.

- A majority of survey respondents also agreed that the draft policy was easy to understand and well organized, and that key terms were defined clearly.

- All feedback received has been posted on a dedicated page of the College's website, along with a comprehensive report of the survey results. A preliminary overview of the feedback was provided to Council in the December 2019 Policy Report.

CURRENT STATUS:

- A revised draft *Protecting Personal Health Information* policy has been developed (**Appendix A**) and updates were made to the *Advice* document (**Appendix B**) in response to stakeholder feedback from the general consultation.

A. Revised Draft *Protecting Personal Health Information* Policy

- While retaining the direction of the majority of the draft policy's expectations, revisions have been made primarily to convey *PHIPA* requirements in clear, plain language; to better align with guidance from the Information and Privacy Commissioner (IPC); and to reflect realities of clinical practice. An overview of the significant changes is provided below.

Clear Communication of PHIPA Requirements

- Revisions have been made to communicate *PHIPA* requirements in a way that emphasizes clear, plain language. For example, provisions 1 and 2, which set out foundational *PHIPA* obligations regarding the protection of PHI, have been reworded and reformatted in response to Council feedback that these concepts could be conveyed more clearly.

- Similarly, in response to response to feedback from Council and the IPC, the revised draft adopts clearer wording to convey the *PHIPA* requirements in situations where physicians must obtain consent from minors (provision 6).

[4] 14 written responses and 21 survey responses.

Lockboxes

- In response to feedback from Council and the Canadian Medical Protective Association (CMPA), the draft policy has been revised to more clearly convey that physicians may, in certain circumstances, disclose information in a lockbox without the patient's consent (provision 8).

    - This includes specific reference to situations where disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to a person or group of people, in which case physicians are permitted to disclose PHI without consent.

- Council also requested further clarity in the policy about the College's expectations in situations where a physician provides care to a patient knowing there is relevant PHI in a lockbox that cannot be disclosed to them. In response, the draft revised policy:

    - maintains the requirement that physicians first consider whether the lockbox prevents them from safely providing treatment, while adding that this analysis must take into account the patient's best interests (provision 10); and

    - creates a new expectation requiring physicians, where they do provide care, to explain to the patient the risks and limitations of proceeding, and to document this discussion in the patient's medical record (provision 10.a.).

Communications with Colleagues

- The draft policy required physicians, when communicating electronically with colleagues, to be assured that the technology being used by the colleague was secure. This provision has been removed from the revised draft in response to feedback from the CMPA and individual physicians that it imposed an unreasonably onerous expectation.

E-communications and Mobile Devices: Encryption Requirement

- The draft policy required physicians to use "reasonable security safeguards" (including encryption, strong passwords, and secure wireless networks) when communicating PHI electronically and via mobile devices. This has been revised to centre on an "encryption" requirement, rather than "security" (provisions 13, 14, and 15).

    - This change has been made in response to feedback from the CMPA, which noted that IPC expectations and orders in this area focus on "encryption".

    - The *Advice* document has also been revised to provide additional guidance around the meaning of "encryption", including a new definition that relies on information

from the IPC about encryption as well as links to additional IPC guidance and relevant orders.

E-Communications: Patient Consent

- The draft policy required physicians to obtain patient consent prior to using any e-communications, whether the e-communications were secure or unsecure.

- The draft has been revised so that express consent is no longer required when using encrypted e-communication; however, a new element has been added to require physicians to use encrypted e-communication when communicating PHI to patients where possible (provision 14).

- In addition, provisions 14.a., b., and c. have been revised to set out expectations, which reflect IPC guidance, where the use of encrypted e-communication with patients is not possible. This includes requiring physicians to first consider whether unencrypted e-communications is reasonable in the circumstances and, if so, that physicians obtain the patient's express consent to this form of communication.

    - These changes have been made in response to feedback from the IPC and the CMPA, which both noted that the IPC does not require express consent for encrypted e-communication. The CMPA recommended that we align with the IPC in this area.

Photographs and Video Recordings

- The draft policy required physicians to seek express consent prior to taking a photograph or video recording that identifies a patient.

- Feedback from OntarioMD and CPSO senior staff led the Working Group to revise the draft to accommodate the reality of how photos and videos are used to provide care in clinical practice, while at the same time incorporating supporting mechanisms to meaningfully protect PHI, such as the secure destruction of back-up copies. As a result, the draft policy has been revised to:

    - remove the requirement that physicians obtain express consent;
    - retain requirements that physicians *inform* the patient about the purpose of the photograph or recording, and that a copy of the photograph or recording be included in the medical record (provisions 16.a. and b.); and
    - require that physicians permanently delete and/or destroy any back-up copy of the photograph or recording (provision 16.c.).

- An explanatory footnote has also been added to clarify that different considerations will apply where the photograph or recording is *not* for providing care or for documentation purposes (i.e. for educational or advertising purposes).

NEXT STEPS:

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and will replace the current *Confidentiality of Personal Health Information* policy on the College's website.

DECISION FOR COUNCIL:

1. Does Council approve the revised draft *Protecting Personal Health Information* policy as a policy of the College?

Contact: Heather Webb, ext. 753
Date: February 13, 2020

Attachments:

Appendix A: Revised Draft *Protecting Personal Health Information* Policy
Appendix B: Revised Draft *Advice to the Profession: Protecting Personal Health Information* Document

Appendix A

Protecting Personal Health Information

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Circle of care: the group of health care providers (e.g. nurse, physician, resident, clinical clerk, and any other health care practitioner providing care to the patient) treating a patient who need the patient's personal health information in order to provide health care. This can also include employees and/or administrative staff who need the personal health information to carry out their duties.

A person outside a patient's circle of care would include:

- a person or entity who is not a health care provider (e.g. family, friends, the police, an insurance company, or the patient's employer); and
- another health care provider, including a physician, where the PHI is being provided for a purpose other than providing health care to the patient (e.g., for research).

For further information and examples, see the *Advice to the Profession* document.

E-Communications: electronic communication tools including email, messages transmitted through electronic medical record platforms, online forums, patient portals, social media applications, instant messaging and texting, and telemedicine (including audio and videoconferencing).[1]

Lockbox: a term used to describe a patient's express instruction to withhold or withdraw their consent to disclose all or part of their personal health information to another health care provider.[2]

[1] See the CPSO's *Telemedicine* policy for additional expectations regarding telemedicine.

[2] The concept of a lockbox is also sometimes referred to as "masking." When proclaimed in force, Part V.1 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (hereinafter "*PHIPA*") will govern "consent directives" and "consent overrides," which are similar concepts to the lockbox in the context of the provincial Electronic Health Record.

Mobile device: includes, for example, a mobile phone, laptop, USB drive, external hard drive, tablet, and wearable device.

Personal health information (PHI): any information relating to a person's health that identifies the person, including, for example, information about their physical or mental health, family health history, information relating to payments or eligibility for health care, and health card numbers.[3]

Substitute decision-maker (SDM): a person authorized to consent on behalf of a patient to the collection, access, use, or disclosure of PHI about the patient.

Policy

This policy includes legislative requirements and professional obligations of physicians related to the privacy and confidentiality of patients' PHI. It does not, and is not intended to, set out all of the legislative requirements regarding privacy and confidentiality of PHI. Physicians are responsible for ensuring that they comply with all of the legislative requirements; the complexity of the law in this area may warrant independent legal advice in specific circumstances.

General

1. Physicians **must** only collect, access, use, or disclose a patient's PHI:

    a. in situations where:

        i. the patient or SDM has provided consent, and it is necessary for a lawful purpose;[4] or
        ii. it is permitted or required by law without consent;[5] and

    b. where they need the PHI to carry out their duties.

2. Physicians **must not**:

[3] This list is non-exhaustive; a full legislative definition, along with certain exceptions, is found s. 4 of *PHIPA*.
[4] Generally speaking, activities associated with the normal course of a physician's practice as they relate to the provision of health care will be for a "lawful purpose".
[5] These situations include specific permissions and requirements set out in *PHIPA* and other legislation, such as reporting obligations outlined in the CPSO's *Mandatory and Permissive Reporting* policy. See the *Advice to the Profession* document for further guidance.

a. collect, access, use, or disclose a patient's PHI if other information will serve the purpose; and
b. collect, access, use, or disclose *more* PHI than is reasonably necessary to meet the purpose.[6]

Obtaining Consent to Collect, Access, Use, or Disclose PHI[7]

Under the *Personal Health Information Protection Act, 2004* (*PHIPA*), consent may be either express or implied.[8] Physicians who have received PHI from the patient, SDM, or another health care provider for a health care purpose can rely on the patient's implied consent to disclose the PHI within the patient's circle of care, unless they have reason to believe that the patient has expressly withheld or withdrawn consent to do so.

The rules governing consent to decisions involving personal health information are found in *PHIPA* and are different from those governing consent to treatment found in the *Health Care Consent Act, 1996*.[9]

3. Except as permitted or required by law, physicians **must** obtain the patient's express consent before:

   a. collecting, accessing, or using PHI where they are outside the patient's circle of care in the circumstances; and
   b. disclosing PHI to a person who is outside the patient's circle of care.

4. For consent to be valid, be it express or implied, physicians **must** ensure that it:

   a. is obtained from the patient, if they are capable of consenting, or the SDM, if the patient is incapable;[10]

---

[6] See s. 30 of *PHIPA*. It is also an act of professional misconduct for a physician to give "information concerning the condition of a patient or any services rendered to a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required by law": O. Reg. 853/96, "Professional Misconduct," s. 1(1)10.

[7] While *PHIPA* establishes rules about the collection, use, and disclosure of PHI, this policy largely focuses on expectations related to disclosure given the particular relevance to physicians' practice.

[8] Express consent is direct, explicit, and unequivocal, and can be given either verbally or in writing. Implied consent is inferred from the words or behaviour of the patient, or surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given.

[9] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (hereinafter "*HCCA*").

[10] Patients are capable of consenting if they are able to understand information relevant to deciding whether to consent to the collection, use, or disclosure of their PHI, and to appreciate the reasonably foreseeable consequences of giving, not giving, withholding, or withdrawing their consent.

b. is reasonable to believe that the patient knows the purposes of the collection, use, or disclosure, and that they may give or withhold consent;[11]
c. relates to the information; and
d. is not obtained through deception or coercion.[12]

Consent from Minors

5. Where a patient is capable of consenting to a decision about their PHI, physicians **must** obtain consent from the patient directly, regardless of the patient's age.[13]

6. Where a capable patient is younger than 16 years old, and the information does *not* relate to a treatment decision[14] the patient has made, *PHIPA* permits the patient's parent to *also* give or refuse consent to a decision about the patient's PHI.[15] However, in these cases, physicians **must** respect the patient's decision over a conflicting decision by the parent.

Lockboxes

7. Where a patient indicates an interest in creating a lockbox, physicians **must**:

    a. engage in a discussion with the patient about the potential health risks and limitations, and implications associated with lockboxes; and
    b. document this discussion and the patient's decision in the patient's medical record.

8. Physicians **must not** disclose PHI in a lockbox unless consent is obtained or the disclosure is permitted or required by law (such as where there are reasonable and probable grounds to believe that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to a person or group of people, including the patient).[16]

9. Where the patient has not consented to the disclosure of PHI that is reasonably necessary for providing care and the disclosure is not permitted or required by law, the disclosing

[11] Section 18(1)(b) of *PHIPA* describes this component of valid consent as "knowledgeable".
[12] See sections 18 to 28 of *PHIPA* for further information regarding the tests for consent and capacity to make decisions regarding the collection, use, and disclosure of PHI.
[13] In doing so, physicians are entitled to presume capacity unless there are reasonable grounds to believe otherwise.
[14] This includes "treatment" as defined in accordance with the *HCCA* and counselling provided under the *Child, Youth, and Family Services Act, 2017*, S.O. 2017, c. 14, Sched. 1.
[15] *PHIPA* specifies that "parent" in this context does not include a parent who has only a right of access (i.e. visitation) to the child and not decision-making authority.
[16] The *Advice to the Profession* document provides additional examples of disclosures that can be made without consent.

physician **must** notify the recipient physician or other health care provider of the fact that there is additional relevant PHI that cannot be disclosed.

10. Having received this notification, the recipient physician **must** then consider whether the lockbox prevents them from safely providing care, taking into account the patient's best interests.

    a. Recipient physicians who provide care to the patient without access to the PHI in the lockbox **must**:

        i. explain to the patient the risks and limitations of proceeding without disclosure of the PHI; and
        ii. document this discussion in the patient's medical record.

    b. Where the recipient physician declines to provide care in these circumstances, the disclosing or recipient physician, as appropriate, **must**:

        i. explain the decision and reasoning to the patient; and
        ii. document this discussion in the patient's medical record.

Security of Communications

11. Physicians **must** take reasonable steps to protect PHI, including protection against theft, loss, and unauthorized access, use, and disclosure of PHI.[17]

12. In particular, physicians **must** take reasonable steps to protect PHI from being inadvertently disclosed without authorization through:

    a. in-person and telephone conversations, including as a result of being overheard by others (e.g., other patients in reception or emergency room areas);
    b. voicemail messages left for patients, taking into account that more than one person may have access to voicemail at the patient's home or office;
    c. faxes, including as a result of being sent to, or intercepted by, unintended recipients; and
    d. email, telemedicine, social media, and any other form of e-communication.

[17] Section 13(1) of *PHIPA* also requires physicians acting as health information custodians to ensure that records of PHI in its custody or control are retained, transferred, and disposed of in a secure manner.

13. Physicians **must** use encrypted e-communication when communicating PHI to other health care providers, unless there is an emergency or other circumstance that requires the use of unencrypted e-communication.[18]

14. Physicians **must** use encrypted e-communication when communicating PHI to patients, where possible.

    a. If encrypted e-communication is not possible (i.e., because the patient does not have access to encrypted e-communication technology), physicians **must** consider whether it is reasonable to communicate with patients through unencrypted e-communication, taking into account:

        i. the degree of sensitivity of the PHI being communicated;
        ii. the volume of information and frequency of e-communication;
        iii. the purpose of the transmission;
        iv. patient expectations;
        v. the availability (or lack thereof) of alternative methods of communication; and
        vi. any emergency or other urgent circumstances.

    b. Where using unencrypted e-communication to communicate PHI to patients, physicians **must** obtain and document the patient's express consent to this form of communication.[19]

    c. When obtaining the patient's express consent to use unencrypted e-communication, physicians **must** inform the patient about:

        i. how this kind of e-communication will be used;
        ii. the type of information that will be communicated;
        iii. how the e-communication will be processed; and
        iv. the limitations and risks of using unencrypted e-communication.

[18] See the *Advice* document for further information about encrypted e-communication tools.

[19] As a way of recording the patient's express consent, consult the written consent form template prepared by the Canadian Medical Protective Association.

Security of Mobile Devices and the Cloud

15. When using mobile devices or cloud-based servers to access, store, or back up PHI – even temporarily – physicians **must** ensure that the PHI on the device or server is protected by encryption.

Photographs and Video Recordings

16. If photographs or video recordings of a patient are required for providing care and/or for documentation,[20] physicians **must**:

    a. inform the patient about the purpose of the photograph or recording;
    b. include a copy of the photograph or recording in the patient's medical record; and
    c. permanently delete and/or destroy any back-up copy of the photograph or recording in accordance with *PHIPA*.[21]

Privacy Breaches

17. Physicians **must** comply with all applicable legislative and regulatory requirements in the event of a privacy breach, including notification and reporting requirements.[22]

[20] Different considerations will apply where the photograph or video recording is *not* for the purpose of providing care; e.g. where it is for educational purposes (see the *Advice to the Profession* document) or advertising purposes (see Part II of O. Reg. 114/94 made under the *Medicine Act*).

[21] This will include any digital copies stored in the cloud. For further information, see s. 13(1) of *PHIPA* and the IPC's Fact Sheets on *Secure Destruction of Personal Information* and *Disposing of Your Electronic Media*.

[22] See the CPSO's *Mandatory and Permissive Reporting* policy for physicians' obligations around privacy breaches.

Appendix B

Advice to the Profession: Protecting Personal Health Information

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Protecting patients' personal health information (PHI) is fundamental to providing high quality patient care. To establish and preserve trust in the physician-patient relationship, patients must be confident that their PHI is protected. This Advice document is intended to help physicians interpret and understand the legal and professional obligations to protect patients' PHI. If you are uncertain about how to discharge any of these obligations in specific circumstances, consult the Canadian Medical Protective Association (CMPA), your legal counsel, or the Information and Privacy Commissioner (IPC).

General Principles

What is the difference between confidentiality and privacy?

Patients' PHI is protected when it remains confidential and private. Physicians are generally familiar with the duty of confidentiality, which prohibits them from *sharing* information about a patient without authorization. In contrast, the duty of privacy is broader and prohibits physicians from *accessing* PHI where they have no authority to do so. At its essence, it is the difference between "don't share" and "don't even look!"[1]

These principles are reflected in the *Personal Health Information Protection Act, 2004* (*PHIPA*), which sets out a framework for when health information custodians and their agents, including physicians, are authorized to collect, use, and disclose PHI. Generally speaking, physicians may only access PHI with patient consent and on a "need to know" basis, unless they are otherwise permitted or required to do so by law.

What is "snooping"?

Snooping is when a health care provider accesses a patient's PHI without authorization – in other words, when they have no "need to know" as part of their duties, and are not otherwise permitted or required by law to access the PHI.

[1] Kate Dewhirst, "New snooping case for health privacy – Decision 74 of the IPC released," September 5, 2018.

Some health care providers mistakenly believe that they are permitted to review a patient's PHI so long as they maintain the patient's confidentiality by not sharing it with anyone else. In reality, snooping is a breach of patient privacy; physicians with technical sign-in ability to an electronic records system do not have authority to access *all* records in the system and may be snooping if they view a patient's records where they do not need that information to provide care.

PHIPA refers to "health information custodians" and "agents". What are these?

A "health information custodian" ("custodian") is a person or organization who, as a result of their power, duties, or work, has custody or control of PHI. This includes health care organizations such as hospitals, pharmacies, and laboratories, as well as some individual physicians (such as owners of a clinic and physicians working as a sole practitioner in their own practice).[2]

In contrast, an "agent" is a person who is authorized by a custodian to perform certain activities on its behalf regarding PHI. Generally speaking, this includes physicians practising in hospitals and certain medical clinics, as well as administrative staff in a medical clinic or hospital. Custodians are ultimately responsible for PHI, as well as the actions of their agents.

While *PHIPA's* framework is complex, custodians and agents are ultimately obliged to meet the same general expectations regarding the collection, use, and disclosure of PHI. The expectations in the policy therefore apply to *all* physicians, regardless of whether they are a custodian or an agent, as does the guidance in this Advice document unless noted otherwise.

However, if you are a custodian, you should be aware of additional *PHIPA* rules that apply specifically to custodians, such as those regulating the retention, transfer, and destruction of records. If you are a custodian, you are advised to consult *PHIPA* and the CPSO's *Medical Records Management* [hyperlink] policy for further information regarding these obligations.

Who is found within the "circle of care"?

The term "circle of care" is not found in *PHIPA*, but is commonly used to determine whether a physician can rely upon implied consent to collect, access, and share PHI. The circle of care is made up of health care providers who need access to the patient's PHI in order to provide the patient with health care.

- In an office setting, the circle of care may include the physician, a nurse, a specialist or other health care practitioner referred by the physician, any other health care practitioner selected by the patient (such as a pharmacist or physiotherapist), and administrative staff who need PHI to carry out their duties (for example, scheduling appointments).

[2] This list is non-exhaustive; a full legislative definition, along with certain exceptions, is found s. 3 of *PHIPA*.

- In a hospital setting, the circle of care may include the attending physician and the health care team (residents, nurses, clinical clerks), administrative staff who need PHI to carry out their duties, and people outside the hospital who will be providing health care upon the patient's discharge.

The circle of care does *not* include:

- Health care providers who are not part of the direct or follow-up treatment of a patient, as these individuals do not need the PHI to provide health care to the patient; and
- Non-health care providers, like family, friends, the police, an insurance company, and the patient's employer.

For further information, see the IPC documents *Frequently Asked Questions: Personal Health Information Protection Act* and *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*.

When do I enter and exit the circle of care?

PHIPA does not address timing with respect to when a physician formally enters or exits the circle of care. Determining if you are within the circle of case will be an assessment based on the role you are playing in the patient's care.

As an example, if you have treated the patient and are continuing to provide follow-up care, you are still within the circle of care and may assume you have implied consent to access their PHI to provide health care. However, a physician does not necessarily continue to be in a patient's circle of care indefinitely. If you are no longer directly providing health care and/or follow-up treatment, you may no longer have the right to rely on implied consent to access the patient's PHI.

When in doubt, check with your custodian (e.g., hospital), legal counsel, and/or the CMPA to find out if you are permitted to access the patient's PHI.

How much information can I leave in a voicemail?

While physicians always have an obligation to maintain patient confidentiality, regardless of the mode of communication (i.e., phone, letter mail, email, etc.), not all information is equally sensitive. Moreover, when scheduling appointments, it is often essential to the provision of care that this information be communicated quickly and effectively.

To that end, the College is not prescriptive about how physicians should communicate appointment information with patients. However, it would generally be reasonable to leave voicemails to share basic appointment information, so long as additional, sensitive health

information is not included. What is reasonable is different in each situation and you will need to exercise some judgment in considering factors like whether the voicemail will be accessible to people other than the patient. As a best practice, consider regularly reviewing with patients their preferred mode of communication, including whether their voicemail is private or shared.

Can I access a patient's PHI for education or quality improvement purposes?

It is common for physicians to want to access a patient's PHI in order to understand and assess the outcome of their treatment decisions, and *PHIPA* permits this kind of activity in certain circumstances for physicians who act as agents.

Under *PHIPA*, a custodian may permit its agents to use PHI without consent in some limited ways, including:

- education, such as where cases are reviewed with trainees and/or presented during rounds (though PHI should not be used where other non-identifying information will meet the purpose); and
- risk management, error management, and quality improvement, such as where patient outcomes are reviewed to evaluate the effectiveness of personal practice or programs.

If you are an agent, your custodian may permit you to access PHI for these purposes, subject to any restrictions or conditions the custodian may have imposed. If your custodian has not expressly permitted you to access PHI for these purposes, you may not do so. You should therefore exercise caution and ensure you have proper authority to access a patient's PHI in these situations – when in doubt, check with your custodian to find out if you are permitted to do so.[3]

If you are a custodian, *PHIPA* also permits you to disclose a patient's PHI to certain other custodians where:

- you and the other custodian have both provided health care to the same patient; and
- you are disclosing the PHI to improve or maintain the quality of care provided to that patient or to other patients receiving similar health care.

These rules permit custodians to discuss with each other the treatment and outcomes of care they have provided to a patient. For further information you may refer to s. 39(1)(d) of *PHIPA*.

In any of the above circumstances, keep in mind that accessing information about a patient's condition or outcome simply out of interest is *never* permitted under *PHIPA*.

[3] PHI viewed through the province's Electronic Health Records Services, such as ConnectingOntario ClinicalViewer, may be subject to additional restrictions on use and disclosure. For further information regarding the appropriate use of ConnectingOntario ClinicalViewer, see the resources available through Ontario Health.

What do I do if a patient requests that their PHI be placed in a lockbox?

Where a patient asks for restrictions on who can access their PHI, consider speaking with them to determine if there are specific concerns about their care or underlying issues that need to be addressed.[4] In accordance with the policy, you must have a conversation with them about the risks, limitations, and implications of creating a lockbox on the patient's ability to receive health care. This may include notifying the patient that the existence of the lockbox may have to be disclosed in the future to a physician to whom you refer the patient. The purpose of this discussion is to promote clear communication between the patient and physician, and may also provide an opportunity for the patient to reconsider the existence of the lockbox for the purpose of the treatment.

Unique considerations may apply in an emergency. *PHIPA* is not intended to prevent the sharing of vital information in critical or emergency situations affecting individuals or public health and safety.[5] In particular, as noted below, PHI may be disclosed without the patient's consent in situations where the disclosure is necessary for eliminating or reducing a significant risk of serious bodily harm to a person or group of persons, including the patient.

Permitted and Required Disclosures

In what situations am I permitted to disclose PHI without consent?

In some circumstances, *PHIPA* permits physicians to disclose PHI without consent. In some of these cases – including a), b), c), e), and f) below – disclosure is only permitted at the discretion of the custodian. If you are acting as an agent, check with your custodian to see whether the disclosure is permitted.

a) **Assisting in a police investigation.** While permitted under *PHIPA*, you are not required to disclose PHI to police in the absence of a court order. The CMPA generally advises physicians to refrain from doing so unless the patient has consented or the disclosure is otherwise required by law. For further guidance, consult the CMPA's *Physician interactions with police* document, with legal counsel, and/or the CMPA.
b) **Eliminating or reducing significant risk of serious harm** to a person or group of persons. It is good practice to document all activities in this respect in the patient's medical record.
c) **Facilitating health care**. If the disclosure is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the patient's consent in a timely manner, you may disclose relevant information to other physicians and certain other health professionals unless the patient has expressly instructed you not to.

[4] CMPA, *Did you know? Patients can restrict access to their health information*, November 2017.
[5] IPC, *Frequently Asked Questions: Personal Health Information Protection Act*, pp. 29-30.

d) **Reporting physician (or other health care provider) incapacity and incompetence**, where this is appropriate in the circumstances.

e) **Regulating the medical profession**. You are permitted to disclose PHI to the CPSO for the purpose of administering and enforcing the *RHPA, 1991*, including carrying out regulatory duties such as investigations and assessments.

f) **A proceeding or contemplated proceeding** in which you or your hospital is, or is expected to be, a party or witness.

This list is not exhaustive; please refer to sections 38-50 of *PHIPA* and the CPSO's *Mandatory and Permissive Reporting* policy for further information.

Where you plan to make (or have made) a disclosure in any of these circumstances, consider whether it would be appropriate to speak with the patient about the reason for the disclosure and what information was disclosed in order to maintain open communication.

In what situations am I required to disclose PHI without consent?

In some circumstances, you are required by the law to disclose a patient's PHI, regardless of whether the patient consents. While not an exhaustive list, the following examples provide an overview of the circumstances you might encounter most frequently:

- **Mandatory reports** listed in the CPSO's policy on *Mandatory and Permissive Reporting*, including reports of suspected impaired driving ability under the *Highway Traffic Act* and reports to the Ontario Coroner under the *Vital Statistics Act* and the *Coroners Act*.
- **Disclosures required by the Ministry of Health** in order to monitor or verify claims for payment for health care, or for goods used for health care that are funded by the Ministry.
- **Reports required by the Workplace Safety and Insurance Board** in circumstances where health care is being provided to a worker claiming benefits under their workplace insurance plan.
- **Critical incident reports**, as required by the "Hospital Management" regulation[6] under the *Public Hospitals Act*.
- **Search warrants** (which grant the police broad authority to search for and seize evidence, including records) and **court summons** (which may require you to attend court with specific documents or materials). In these cases, consult legal counsel and/or the CMPA, including their resources on physician interactions with police.

[6] R.R.O. 1990, Reg. 965.

Where you plan to make (or have made) a disclosure in any of these circumstances, consider whether it would be appropriate to speak with the patient about the reason for the disclosure and what information was disclosed in order to maintain open communication.

Where can I find further information about privacy breaches?

A "privacy breach" refers to a theft, loss, or unauthorized access, use, or disclosure of PHI that contravenes *PHIPA*. Custodians are responsible for reporting privacy breaches to the affected individuals, the IPC, and/or the CPSO in specific instances. Custodians are also required to report certain information annually to the IPC. For information, see the CPSO's *Mandatory and Permissive Reporting* policy and the IPC documents *Responding to a Health Privacy Breach: Guidelines for the Health Sector*, *Reporting a Privacy Breach to the IPC*, and *Annual Reporting of Privacy Breach Statistics to the Commissioner*.

Information from Third Parties: Friends, Family, and Research

This section deals with requests for patient information from third parties. In all of the following scenarios, the general rules under *PHIPA* apply: unless otherwise permitted or required by law, PHI can only be shared with third parties with the express consent of the patient.

What do I do if a friend or family member, who is not the patient's SDM, requests access to the patient's medical information or records?

It is not uncommon for physicians to be asked by a family member or friend about the condition of a patient or for information about the patient's health. These situations can be challenging to manage, as the circumstances under which *PHIPA* allows you to do so are limited.

In the context of facilities that provide health care (e.g. hospitals or psychiatric facilities), you may disclose the following PHI about a patient or resident of the facility if the patient or resident is offered, at the first reasonable opportunity following admission, the ability to object to the disclosure:

- the fact that the individual is a patient or resident in the facility;
- the individual's general health status described as critical, poor, fair, stable or satisfactory, or in similar terms; and
- the location of the individual in the facility.

In the context of psychiatric facilities, the *Mental Health Act* also allows PHI about a patient to be collected, used, or disclosed (with or without the patient's consent) for, among other reasons, examining, assessing, observing or detaining the patient in accordance with the Act.

PHIPA also permits you to disclose PHI where the disclosure is required to contact a relative, friend, or potential SDM if the patient is injured, incapacitated, or ill and unable to give consent personally.

When managing a request for information from family or friends, use your professional judgment and limit disclosure about the patient's state of health unless one of the above circumstances applies.

How do I manage a request for PHI from a family member where the patient has died?

PHIPA allows you to disclose PHI without consent in limited circumstances where the patient has died, including where the PHI is required to identify the patient, advise of the patient's death and (where appropriate) the circumstances of death, and provide information that relates to the patient where it is needed by a spouse, partner, sibling, or child to make health care decisions.

In most other situations, consent will be required before you can disclose PHI about a deceased patient. Consent will need to be obtained from the deceased's estate trustee (the executor) or, if there is no trustee, the person who has assumed responsibility for the administration of the estate. A person who was the power of attorney while the patient was alive will no longer have authority to provide consent, unless that same person is the estate trustee or administrator. Consider requesting confirmation of who the estate trustee is, such as by asking for a copy of the will or a letter from the patient's or family lawyer. If there is no trustee, consider asking for a lawyer's letter advising who has assumed responsibility for administration of the estate.

What do I do if a child patient's parent or a third party requests access to the patient's PHI?

There may be instances where you are asked to disclose PHI to a patient's parents or a third party, like a lawyer or mediator, including in situations where a child patient's parents have separated or divorced. In all cases, you must obtain consent directly from the child patient where they have capacity to make the decision, even if they are accompanied by a parent or guardian. Physicians can rely on a presumption that individuals, regardless of age, are capable of consenting to the collection, use, or disclosure of PHI unless there are reasonable grounds to believe otherwise.

In cases where a capable patient is under the age of 16 and the information in question does *not* relate to a treatment decision[7] the patient has made, *PHIPA* allows parents to *also* consent. Even here, however, the patient's decision will govern over a conflicting decision of their parent.

[7] This includes "treatment" as defined in accordance with the *HCCA* and counselling provided under the *Child, Youth, and Family Services Act, 2017*, S.O. 2017, c. 14, Sched. 1.

When seeking consent from a parent, it is important to know that parents with only a right of access to the child (as opposed to custody) are not permitted by *PHIPA* to provide consent. A family court order or a separation agreement may specify who has custody of and access to the child, and therefore who may make decisions about the child's PHI. Consider requesting a copy of the applicable court order or separation agreement prior to releasing any information and keeping it in the patient's medical record.

How do I manage a request for PHI in the context of couple, family, or group therapy?

Where therapy is being provided in a group setting, the consent obtained from the patients will generally set out how their PHI will be shared amongst the therapy participants. However, special considerations may apply where PHI is recorded as part of an assessment of an individual patient within a group therapy context, or where a patient receives a combination of individual and group therapy. Be mindful that the patient may not have consented to sharing this specific PHI with the group and that you may need to protect it accordingly.

Where a third party (e.g. a mediator, lawyer, or the court) requests records relating to couple, family, or group therapy, the general *PHIPA* rule applies: you may not disclose PHI without patient consent unless permitted or required to do so by law. In a therapy setting involving more than one patient, consent may be required from all the patients involved in the therapy, and the consent will need to be specific to the material requested. [8]

Can I use PHI for research purposes?

Physicians sometimes undertake research using their own patients as participants. In other cases, they are requested by industry to identify eligible patients or to release general patient data for research that will be conducted by third party researchers.

PHI must only be used or disclosed for research purposes with patient consent or as permitted by law – that is, where the research ethics board that has approved the research has concluded that it is impractical to obtain patient consent and proper safeguards have been put in place.

Where PHI will be used or disclosed (either with consent or as permitted by *PHIPA*), you are reminded to only use or disclose as little PHI as possible to meet the research needs and to de-identify the PHI whenever possible.

What are my obligations as an Independent Medical Examiner (IME)?

[8] Section 52(3) of *PHIPA* also states that where a record is not dedicated primarily to PHI about the person requesting access to it, they have a right of access only to the PHI in the record that can "reasonably" be separated from the rest of record.

An IME is a physician who provides a third party report about an individual with whom the physician does not have a treating relationship. These reports are prepared for a third party process (e.g. a legal proceeding), instead of for a health care purpose. The provisions of *PHIPA* therefore do not apply in this context; instead, the federal *Personal Information Protection and Electronic Documents Act* will apply to the collection, use, and disclosure of personal information for this purpose. Given that different rules govern the preparation of third party reports and the conduct of a medical expert, please see the CPSO's *Third Party Reports* and *Medical Expert: Reports and Testimony* policies for further information.

Technology and e-Communication

What are the benefits and risks of e-communication?

Technology has provided physicians and patients alike with a more efficient way of maintaining and communicating PHI. The CPSO recognizes and encourages physicians to capitalize on the advantages that electronic record-keeping and e-communications have to offer.

At the same time, one of the major risks of using modern technology to communicate PHI is that the PHI will be inadvertently disclosed to someone who should not have it. This can happen in a variety of ways:

- Wifi networks and telemedicine communications can be unsecure (particularly free wifi networks in public places);
- Emails can be sent to the wrong recipient or otherwise intercepted;
- Unauthorized readers can access computer files;
- Mobile devices can be lost or stolen; and
- Erased hard drives or USBs can contain private information.

Ultimately, e-communication may be best suited for minor tasks, such as scheduling appointments and appointment reminders, and not for urgent or time-sensitive health issues.

What are the rules around video surveillance of patients and premises?

The highest security precautions need to be taken to protect patient privacy where video surveillance is used in a health care setting. While the most common use of this activity is for building security, physicians need to be aware that highly sensitive PHI may be collected in the process.

The IPC provides guidance for health care providers who employ video surveillance. For further information, see the IPC's *Fact Sheet on Wireless Communication Technologies: Video Surveillance Systems* and the blog post *Cameras in Doctors' Exam Rooms? Not in Ontario*.

Can a patient record their appointment with me? Can they take a picture of their chart?

It is becoming increasingly common for patients to want to record their medical appointments via audio, video, or photography. In many cases, these recordings can benefit patients by helping them understand and remember the information they are being provided. However, recordings also have the potential to raise broader issues, including patients recording in public areas (such as waiting rooms) and physicians being recorded without their knowledge.

The CMPA provides guidance to physicians to manage these situations. For further information, see the CMPA's document *Smartphone recordings by patients: Be prepared, it's happening*.

What is encryption and what kinds of e-communication are encrypted?

Encryption technology helps secure PHI against unauthorized access and disclosure. Encryption scrambles the contents of a message so that only those with access to a key or password can unscramble and read it. According to the IPC, most secure email solutions involve end-to-end encryption, allowing the sender to be confident that only the intended recipient will read the email. The recipient can also be confident that the message is genuine and originated from the sender.

Encryption technology solutions are increasingly available and can often be implemented by installing a simple program or application on your device. In addition, the email program commonly used by health care providers in Ontario, ONE Mail, allows individuals to send and receive personal health information in an encrypted manner when used by both the sender and the recipient. However, physicians may generally assume that outside of secure patient portals and EMR messaging platforms, patient access to encrypted e-communications may be limited.

For further guidance, considering seeking advice from an expert in the area of encryption and technological security. You may also consult the resources available through OntarioMD, the IPC documents *Communicating Personal Health Information by Email* and *Fact Sheet: Encrypting Personal Health Information on Mobile Devices*, and Order HO-004 (2007), which sets out the IPC's encryption standard for mobile devices.

What do I do if a patient sends me an unsolicited email?

With contact information and email addresses becoming readily accessible online, it is also becoming more common for physicians to receive unpromoted or unsolicited emails from patients. In managing these communications, and assuming that the patient is using unencrypted technology, the policy requires physicians to consider whether it is reasonable to communicate with patients through unencrypted e-communication, taking into account the factors set out in provision 15.a.

Where you determine that it is reasonable to use unencrypted e-communication, you must obtain and document the patient's express consent, which requires that you inform them of the information set out in provision 15.c. It is not sufficient to rely on implied consent based on the fact that the patient initiated the e-communication, since the patient may not be (fully) informed of the risks of communication PHI over unsecure email. Where you determine in the circumstances that it is not reasonable to communicate through unencrypted e-communication, consider suggesting that the patient use a more secure alternative method of communication.

Council Motion

Motion Title: Advertising – Draft for Consultation

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

The College engage in the consultation process in respect of the draft policy “Advertising” (a copy of which forms Appendix “ ” to the minutes of this meeting).

CPSO

Council Briefing Note

March 2020

TOPIC: *Advertising* – Draft Policy for Consultation

FOR DECISION

ISSUE:

- A draft *Advertising* policy has been developed to help provide clarity or address areas of ambiguity with respect to the expectations for physician advertising set out in the General Regulation under the *Medicine Act, 1991*[1] (the Regulation). A companion *Advice to the Profession* document has also been developed to offer further guidance to physicians.

- Council is provided with an overview of the draft policy and advice document, and is asked whether the draft policy can be released for external consultation and engagement.

BACKGROUND:

- The Regulation, which came into force in 2003, sets out expectations related to physician advertising. This includes:

  - parameters for acceptable and unacceptable advertising;
  - prohibitions on the use of testimonials or references to specific brand names;
  - restrictions on steering or soliciting patronage; and
  - use of title expectations.

- The College previously had an *Advertising by MD*s policy which simply contained the provisions of the Regulation, but this was rescinded in 2008. However, advertising continues to be area in which complaints are received, issues are repeatedly being seen by the Inquiries, Reports, and Complaints Committee (ICRC), and about which questions are regularly being asked.

- The draft policy was developed with direction from the standing Policy Review Working Group, consisting of Brenda Copps (Chair), Ellen Mary Mills, and Janet Van Vlymen as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Kirk Maijala (Legal Counsel) and Michael Szul (Medical Advisor).

---

[1] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

- The following has been undertaken in accordance with the usual policy review process:
    - A literature review, including a jurisdictional scan, was conducted;
    - Decisions of the ICRC were reviewed;
    - Feedback was obtained from departments that regularly address advertising related issues (e.g., Physician and Public Advisory Services).

- In lieu of a public consultation, as there was no existing policy to seek feedback on, additional engagement activities were undertaken including:
    - Public polling to assess public expectations in relation to key issues[2];
    - Engagement with the Citizen Advisory Group[3], both in-person and by online survey;
    - Preliminary meetings with key stakeholders.

CURRENT STATUS:

- In keeping with the policy redesign strategy, the draft has been developed with a focus on clarity, directness, and brevity. For example, the draft exclusively uses the word "must" to signify the "mandatory" nature of the expectations.

- Importantly, the College is limited in its ability to set physician expectations in this area due to the existence of the Regulation. Some of the language of the Regulation has been retained in the draft policy verbatim where necessary, to help ensure physicians are meeting their legal obligations. However, attempts have been made to provide a more plain language alternative, where this could be done while retaining the meaning or intention of the Regulation.

- Throughout the policy new expectations of the College are also set out to address issues not covered by the Regulation. Having both sets of expectations in the policy provides physicians with a single succinct document capturing all their legal and professional obligations.

- An overview of the key draft policy expectations is provided below.

A. Key Expectations of Draft *Advertising* Policy

Advertising content

- The draft policy captures existing requirements of the Regulation regarding appropriate and inappropriate advertising, but includes additional content where needed either to clarify or expand upon the existing requirements.

---

[2] Questions were asked on the appropriateness of advertising, including for medically necessary or elective services, how patients decide on a physician, imagery in advertising, and the use of brand names.
[3] A group consisting of patients and caregivers who have experience with the healthcare system.

- The requirements in the Regulation that advertising be "readily comprehensible, dignified and in good taste" have been retained, but expanded upon as these concepts are relatively ambiguous in nature.

- Prohibitions in the Regulation regarding the content of advertisements (e.g., that advertising not be false, misleading, deceptive, contain a testimonial, etc.) were retained, but additions were made to clarify and expand the range of inappropriate practices (e.g. advertising that is sensationalized, exaggerated, or provocative, that contains any statement that is discrediting, disparaging or attacking in nature, or which offers incentives to the public to seek a medical service).

- An exception has also been added to the Regulation's prohibition on the use of specific brand names in advertising. This exception allows physicians to use a brand name when it has come to be used to describe a product more generally (e.g., use of the term "botox" being used to refer to any botulism toxin).

Before and After Photos or Videos

- The draft policy permits the use of before and after photos or videos (BAPVs) in limited circumstances. In addition to compliance with the advertising expectations that apply broadly, specific expectations have been set out in the draft policy to permit the use of BAPVs only where they would be appropriate, accurate, and educational, and where patients have given free and fully informed consent to their specific use.

  - This is a significant departure from historical interpretations of the ICRC, who have previously taken the view that BAPVs fall within the definition of a testimonial and are therefore prohibited. The draft policy specifically states that BAPVs that comply with the policy will not be considered a testimonial.

  - This new approach is aligned with several other jurisdictions[4], is consistent with the Code of Ethics[5] of key stakeholder organizations, and is responsive to the reality that BAPVs are already in widespread use in physician advertising.

  - It is also supported by evidence from public opinion polling and consultation with the Citizen Advisory Group, which showed that prospective patients want to see BAPVs to assist them in making health care decisions.

[4] For example, both the College's in British Columbia and Manitoba permit the use of BAPV under certain conditions. Many other jurisdictions do not explicitly prohibit their use.
[5] Canadian Society of Plastic Surgeons Code of Ethics, adopted June 2001.

Association with products or services other than their own medical services

- The regulation includes a prohibition that may be interpreted as inadvertently restricting physicians working in a multidisciplinary practice from being associated with advertising for that practice.

- The draft policy interprets this provision in a manner that supports reasonable and appropriate advertising, provided that any advertising for a multidisciplinary practice makes clear which services are provided by physicians, and the advertisement does not contain a physician endorsement of the other services provided at the practice.

B. Draft *Advice to the Profession* Document

- The draft *Advice to the Profession* companion document (**Appendix B**) is intended to provide additional information and general advice in order to support understanding and implementation of the expectations set out in the policy. Issues addressed include what is considered advertising, incentives, use of before and after photos or videos, and use of title.

    - While this document is provided for Council's review and feedback, and will be distributed as part of the consultation, it is intended to be a nimble communications tool which does not require Council approval in the same way a policy requires approval.

NEXT STEPS:

- Subject to Council's approval, the draft policy will be released for external consultation and engagement. Feedback received as part of these activities will be shared with Council at a future meeting and used to further refine the draft.

DECISION FOR COUNCIL:

1. Does Council recommend that the draft *Advertising* policy be released for external consultation?

Contact: Courtney Brown, Ext. 216
Date: February 11, 2020

Attachments:

Appendix A: Draft *Advertising* policy
Appendix B: Draft *Advice to the Profession: Advertising*

Advertising

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Definitions

Advertising: any communication made in print, through electronic media or via the internet by or on behalf of a physician (i.e., by a third party) that has as its primary purpose the promotion of the physician, a service they provide, or a clinic, facility or group with which they are associated. For the purposes of this policy, advertising also includes the communication of the availability of professional services.

Testimonial: a statement endorsing the quality of a service, product or professional. A before and after photo or video that complies with the requirements of this policy will not be considered a testimonial.

Before and After Photo or Video: images of a patient taken before and after a medical service, and used to document the process or demonstrate the result.

Policy

This policy sets out expectations for physician advertising and includes both expectations that are set out in the General Regulation under the *Medicine Act, 1991*[1], and expectations that have been set by the College of Physicians and Surgeons of Ontario.

1. Physicians **must** ensure that any advertisement prepared by them, or on their behalf by a third party, complies with the expectations contained in this policy and the General Regulation under the *Medicine Act, 1991*.

Advertising Content

2. Physicians **must** only advertise in a manner which:
    a. is readily comprehensible;

[1] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

b. is dignified;
c. is in good taste;[2]
d. is accurate and factual;
e. is verifiable and supported by available evidence and science, if making statistical, scientific or clinical claims;
f. is respectful and balanced in tone; and
g. upholds the reputation of the profession.

3. Physicians **must not** advertise in a manner which:
   a. is false, misleading or deceptive (for example, by the inclusion or omission of any information);
   b. is sensationalised, exaggerated, or provocative;
   c. contains any statement that is discrediting, disparaging, or attacking in nature;
   d. contains any statement comparing themselves to other physicians or health professionals;
   e. contains any statement that promises or suggests a better or more effective service than any other physician or health professional;
   f. contains a testimonial;
   g. contains any reference to a specific drug, appliance or equipment, unless the drug, appliance, or equipment is known by its commercial name in a generic sense[3]; or
   h. offers incentives to the public to seek a medical service.[4]

Before and After Photos or Videos

4. In addition to complying with the expectations set out in provisions 2 and 3, physicians **must not** use before and after photos or videos in advertising unless the photos or videos:
   a. are for the purpose of providing accurate and educational information;
   b. portray an outcome that can reasonably and typically be expected;
   c. depict an actual patient who received the advertised medical service from the physician associated with the advertisement;
   d. are not manipulated;[5]
   e. have used consistent lighting, photographic techniques, and setting; and

[2] Advertising that is overly commercial in tone, as opposed to being educational or informational, will be more likely to be in bad taste. For more information on what constitutes "good taste", please see the *Advice to the Profession* document.

[3] For example, "botox" is commonly used to describe a generic botulism toxin rather than the specific brand. For more information on the circumstances when it may be acceptable to reference a specific drug, appliance or equipment, please see the *Advice to the Profession* document.

[4] This provision does not preclude physicians from discussing potential payment options and discounts with prospective patients in their office setting. For more information on what may constitute an incentive, please see the *Advice to the Profession* document.

[5] Changes that aim to misrepresent the results of the medical service would constitute manipulation. Cropping or resizing of images for display would not be considered manipulation provided that consistent techniques are applied to any before and after images.

f. only depict a patient who has been de-identified, unless the patient has consented to being identified.

5. Physicians **must not** use before and after photos or videos in advertising where the physician or practice is paying to have that content reach the public and prospective patients, who are otherwise not seeking out that information.[6]

6. In addition to the requirements set out in the *Personal Health Information Protection Act, 2004* regarding the collection, use and disclosure of personal health information[7], physicians **must** obtain express consent to the specific use of before and after photos or videos before using them in their advertising. As part of this physicians **must**:
    a. wait until after the medical service is provided to discuss and obtain consent to the use of the before and after photos or videos in their advertising;
    b. inform the patient that they can withdraw their consent to the use of before and after photos and videos at any point;
    c. inform the patient about the risks of consenting to the use of before and after photos and videos (for example, that once posted on social media they may be unable to be completely withdrawn);
    d. engage in a dialogue with the patient about the use of the photos or videos, regardless of whether supporting documents (such as consent forms, patient education materials or pamphlets) are used;
    e. consider how the power imbalance inherent in the physician-patient relationship could cause patients to feel pressured to consent to the use of photos or videos and take reasonable steps to mitigate this potential effect; and
    f. **not** offer incentives to consent to the use of before and after photos or videos.

Association with Products or Services Other than their own Medical Services

7. Physicians **must not** permit their name or likeness[8] to be used in or associated with advertising:
    a. for any commercial product or service other than their own medical services, or
    b. for facilities where medical services are not provided by the physician.

8. Notwithstanding provision 7, physicians who are part of a multi disciplinary practice are permitted to be associated with that practice's advertising, however they **must** ensure that advertising for the practice meets the following conditions:

---

[6] As opposed to displaying before and after photos or videos in places where a prospective patient may seek them out. For example, before and after photos and videos can be displayed on a physicians website, but cannot be used in print advertisements in magazines or newspapers, as this would constitute content being "pushed out" to the public. For more information on the use of before and after photos or videos, please see the *Advice to the Profession* document.

[7] *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Sched. A.

[8] For example, a representation, picture or image of the physician.

a. the advertisement does not provide or appear to provide any physician's endorsement of services at the practice not provided by the physician; and
b. the advertisement does not state or imply that a physician provides all of the services offered at the practice, or that a physician provides any services that they do not in fact provide.

Directing and Targeting Prospective Patients

9. Physicians **must not** participate in an organized or co-ordinated effort in which another person directs someone to a particular physician for medical services.[9]

10. Physicians **must not** proactively target and contact, or attempt to contact, any person known to need medical services to solicit them to use their medical services.[10]

Use of Title

11. In any communication that advertises, promotes or relates to the provision of medical services, physicians **must** only reference titles, designations or medical specialties in accordance with the General Regulation under the *Medicine Act, 1991.*[11]

[9] This does not preclude physicians from undertaking a referral or transfer of a patient's sample, in good faith and in compliance with the conflict of interest provisions in Part IV of O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30. For further information please see the *Advice to the Profession* document.

[10] This does not preclude physicians from contacting patients who have been referred to them, reminding a person who has made an appointment of the appointment or from communicating with regular patients to inform them of health maintenance procedures due to be carried out, health issues, preventative medicine and recent developments in medicine, or of a possible benefit from a change in therapy.

[11] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30. For more information on how a physician can refer to themselves in advertising please see the *Advice to the Profession* document.

Advice to the Profession: Advertising

Advice to the Profession companion documents are intended to provide physicians with additional information and general advice in order to support their understanding and implementation of the expectations set out in policies. They may also identify some additional best practices regarding specific practice issues.

Advertising is used by physicians to attract patients to their practice, or to help inform patients about the services, products or treatments they offer. Currently the General Regulation under the *Medicine Act, 1991*[1] (the Regulation) sets out physicians' legal obligations when advertising.

The *Advertising* policy aims to help provide clarity around these rules and set out appropriate professional expectations where the rules of the Regulation are ambiguous or open to interpretation. This will assist physicians in advertising their services effectively, while assuring such advertising is appropriate and in the best interests of the public. Importantly, the policy captures *both* physicians' legal obligations as set out the Regulation as well as additional expectations of the College. This is to assist physicians in understanding their obligations, by having all expectations contained in one document.

This companion Advice document provides further guidance around how the expectations in the Regulation and policy can be met.

What is considered advertising?

As the policy outlines, advertising means any communication that has as its primary purpose the promotion of a physician, or a clinic, facility or group with which the physician is associated. This can be both paid or unpaid and includes:

- print ads in newspapers, magazines, and brochures;
- newsletters and mail outs;
- business cards and stationery;
- logos and signage;
- TV or radio ads;
- websites;
- blogs and social media posts (e.g., Facebook, Twitter, Instagram);
- posters and billboards; and
- other information related to the physician's practice, regardless of the form or the manner of distribution.

Under the Regulation, posters or pamphlets displayed in a physician's office or clinic waiting area are also considered to be advertising.

[1] O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

What is not considered advertising?

While the term "advertising" covers a wide range of materials or activities, there are tools that physicians may use to inform patients that would not be considered "advertising" under the Regulation. Such tools would include materials that physicians use to inform patients about procedures in a clinical setting, for example, showing a patient images or pamphlets when discussing treatment with them during an appointment.

Fundraising efforts on behalf of a foundation or an organization are not generally considered advertising, as the primary purpose is to raise funds and not to attract patients to a particular physician or clinic. That said, there may be instances where the nature of the content is such that it is subject to the Regulation and so the requirements set out there and captured in the policy would apply. It will be important that physicians who choose to be associated with such campaigns use their professional judgement to determine whether it would be appropriate, based on the specific circumstances and content of the campaign.

What kind of advertising content would not be in "good taste"?

The College's Inquiries, Complaints and Reports Committee (ICRC), has in the past found advertising to be "less tasteful" when done for primarily commercial purposes. Advertising that is overly commercial in tone, as opposed to being educational or informational, is more likely to be in bad taste. The setting and size of the advertisement may also inform whether something is in good taste or not. For example, content that may be considered acceptable on a clinic's website, could be in bad taste if displayed on a billboard. Advertising content that is displayed for "shock value" may also be in bad taste. Careful consideration will need to be undertaken when using images that depict devices or images of patients.

What kind of advertising content would be misleading or deceptive?

Content that is false or not based in fact will be in breach of the expectations contained in the policy. However, what would be considered "misleading or deceptive" is broader than this. Thinking carefully about whether the wording of advertisements includes content that may lead the reader to an incorrect conclusion, create a false impression, or that leaves out key information or context, will help physicians meet the expectations contained in the policy.

What are the rules around testimonials on third party sites?

The Regulation prohibits physicians from using testimonials in their advertising.

Internet sites currently exist on which patients and the public can post ratings, reviews and feedback on a particular physician, practice or clinic. These can take the form of testimonials, but there is no prohibition against such sites where the public are freely posting their opinions on a service.

Some behaviour by physicians relating to testimonials on third party sites could potentially be considered a breach of the prohibition against testimonials. For example, if a physician was to direct or

request patients to post about their practice on such sites, or post on such sites themselves under other names.

What should I do with comments on social media posts?

Many physicians choose to maintain a social media presence for themselves or their practice. Social media is a rapidly evolving space and is being used by physicians in a range of ways.

It may be that members of the public post comments on the social media accounts of physicians or their practices. When considering such comments and how they should be handled, physicians will need to use their professional judgement and act in compliance with the College's *Social Media – Appropriate Use by Physicians* statement.

While social media comments by third parties may not on their own be considered advertising, a physician taking an active role in managing social media comments could change the way such comments are perceived. For example, if a physician was to delete negative comments and not positive comments, this could be viewed as a breach of the Regulation and the *Advertising* policy as it relates to testimonials.

When can I use the name of a specific drug, appliance or equipment in my advertising?

Consistent with the intention of the Regulation, the policy notes that physicians cannot use the commercial brand name of a product unless the commercial name has come to be used to describe the product more generally. For example, the use of the word "botox" to describe a generic botulism toxin. This is a narrow exception and would not apply when:

- the name appears in a list of brand name cosmetic surgery products; or
- the name appears with wording promoting the benefits of the brand name product.

For example, this exception does not permit physicians to use the term "botox" in advertising where they are promoting the benefits of the brand Botox in comparison to other similar products. The underlying purpose of the prohibition in the Regulation is to prevent physicians from endorsing specific drugs, and whether a brand name is being used to describe the generic product or the brand name product will depend on the exact wording of the advertisement.

Physicians can of course discuss the specific products and brands they use in conversation with prospective patients. Advertising could note that a physician provides a certain type of treatment and encourage interested partied to contact the physician or clinic for more information on the specific brands and products used.

What kind of things are "incentives to the public to seek a medical service"?

With respect to advertising, incentives mean offerings that attempt to motivate or encourage patients to consider or undertake a particular procedure or treatment, and are often financial, in the form of discounts or special prices. Examples include:

- time-limited prices for a service;
- discount coupons or gift certificates for a service;
- offering treatments or procedures as prizes in a contest;
- offering free products, vouchers or gift certificates not related to the medical service when a patient books or undertakes a medical service.

The prohibition on incentives does not preclude physicians from discussing pricing options and discounts with patients or prospective patients seeking more information about a procedure or treatment. For example, some physicians offer discounts for patients who wish to undertake multiple procedures or treatments at the same time. It would be permissible for physicians to offer such discounts within their practice, but not to promote them in their advertising.

When can I use before and after photos or videos in my advertising?

As stated in the policy, before and after photos or videos cannot be used where content is being "pushed out" to the public. For example, advertising that is published in magazines or newspapers, tv advertisements, or sponsored or promoted posts on social media that appear in the feeds of users who do not follow that physician or practice on social media.

Physicians are permitted to use before and after photos and videos in formats where prospective patients may seek them out, for example on their websites or on their social media pages generally (with no paid targeting or promotion of the posts), provided of course those photos or videos comply with the requirements of the policy.

Careful consideration will need to be given before posting photos or videos to social media, as the terms of use for social media sites can change and evolve, with potentially unforeseen consequences.

What constitutes "permitting" myself to be associated with an advertisement?

All advertising produced by a clinic or practice where a physician provides services, could be associated with that physician. It is important that physicians maintain awareness of any advertising or promotional material published or put out by an organization with which they have a direct connection, and whether that advertising is in compliance with advertising obligations.

Permitting advertising from other businesses, for example business cards or flyers, in the office of a physician's practice could be considered to be an endorsement of the advertised service or product by the physician and would not be permitted by the Regulation.

What constitutes "an organized or co-ordinated effort in which another person directs someone to a particular physician for medical services"?

The Regulation prohibits physicians from participating in a system in which someone else (e.g., a person or a company), directs patients towards them for professional services.

This would not prohibit a physician from recommending another particular physician, practice or clinic, if asked by a patient to do so, or making referrals as part of their normal course of practice.

Physicians offering services through group discount companies have previously been found by the ICRC to be participating in a system in which another person steered patients to a physician for professional services. Offering discounted prices through such sites could also be in breach of the prohibition against offering incentives to the public to seek a medical service.

How should I refer to myself in advertising?

The Regulation contains specific rules for the way physicians can refer to themselves and their areas of practice in advertising. There are a number of terms that are protected and can only be used where physicians have, for example, appropriate certification.

According to the Regulation, when a physician is referred to in any advertising, the physician's name must[2] be followed by either:

a. the term, title, or designation that the physician may use with respect to the specialty or subspecialty of the profession in which the member has been certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC) or formally recognized in writing by the CPSO, or
b. the title "General Practitioner."

Physicians can also have their designatory letters (indicating academic degrees, professional certification from the RCPSC, CFPC or formal recognition from the CPSO) follow their name.

Examples of Proper usage

- Dr. Joan Clark, Family Medicine
- Joan Clark, MD, CCFP, Family Medicine
- Dr. B. Ali, MBA, General Practitioner
- L. Rousseau, MD, CPSO Recognized Specialist (Anesthesia)

<u>Focused Practice</u>

Physicians who have a focused practice, for example, a family physician with a focus on pediatrics, may have completed additional training in specific practice areas but are not certified specialists in those disciplines. In keeping with their professional obligations, physicians must ensure they have the suitable knowledge, skills and judgment to practise in the areas that they describe. If physicians wish to describe other areas of their practice, they may do so, provided physicians comply with certain requirements:

- The physician must still state their specialty or subspecialty or designation as a general practitioner as explained above; and

[2] According to O. Reg. 114/94: GENERAL under *Medicine Act, 1991*, S.O. 1991, c. 30.

- The phrase “practising in” must precede any descriptive terms that are used.

This is intended to ensure consistency in advertising and promotional materials, and that descriptive terms are not mistaken for formal specialization or sub-specialization.

Examples of Proper usage

- Charles Gauthier, MD, CCFP, Family Medicine, practising in pediatrics
- J.B. Rodriques, MD, General Practitioner, practising in psychotherapy

Other Credentials

Physicians can also include their other credentials in their advertising, if they wish, but that information cannot come before the required speciality designation and practice descriptor, if any.

Example of Proper usage

- F. Stevens, MD, General Practitioner, practising in sleep medicine, Diplomate of the American Board of Sleep Medicine

Restricted Practice Description Terms

Some practice description terms are restricted. Physicians cannot use the terms ‘surgeon,’ ‘surgery,’ ‘plastic,’ ‘facial plastic,’ ‘oculoplastic’ and ‘ophthalmic plastic’ unless they satisfy the conditions in the regulation. Specifically:

- No physician can use the title “surgery” or the term “surgeon,” or a variation or abbreviation to describe their practice unless he/she is certified by the RCPSC in a surgical specialty or subspecialty or formally recognized in writing by the CPSO as a surgical specialist or subspecialist.
- No physician can use “plastic” to describe his or her practice unless the physician is certified by the RCPSC in plastic surgery or formally recognized in writing as a plastic surgeon by the CPSO.
- No physician can use “facial plastic” to describe his or her practice unless the physician is certified by the RCPSC as an otolaryngologist – head and neck surgeon or is formally recognized in writing by the CPSO as an otolaryngologist – head and neck surgeon. In keeping with the other requirements of the regulation, otolaryngologists – head and neck surgeons can only use “facial plastic” as a practice descriptor; it can’t replace the full name of their specialty.
- No physician can use “oculoplastic” or “ophthalmic plastic” to describe his or her practice unless he/she has been certified by the RCPSC as an ophthalmologist or is formally recognized in writing by the CPSO as an ophthalmologist. Ophthalmologists must only use these terms as a practice descriptor; they cannot use them instead of the full name of their specialty.

Examples of Proper usage

- M. Liu, MD, FRCSC, Otolaryngology-Head and Neck Surgery, practising in facial plastic surgery
- Bonnie Smith-Fox, MD, CCFP, Family Medicine, practising in cosmetic procedures

CPSO

Council Briefing Note

March 2020

TOPIC: Medical Assistance in Dying - Update

FOR INFORMATION

ISSUE:

- In September 2019 the Superior Court of Quebec struck down one of the eligibility requirements for accessing medical assistance in dying (MAID) in Canada, namely, the requirement that a person's natural death be reasonably foreseeable.

- The federal government opted not to appeal this decision, choosing instead to respond through legislative change in advance of the March 2020 deadline set by the Court. A public consultation was held to inform this legislative work in January 2020.

- Council is provided with a brief overview of the Court decision, the College's involvement in the federal government's consultation processes, and anticipated next steps in the process.

BACKGROUND:

- In June 2016, federal legislation was enacted to establish a legal framework for accessing MAID in Canada. The legislation was developed in response to the landmark *Carter* decision, which struck down the legal prohibitions that prevented practitioners from providing MAID.

- Among other purposes, the legislation set out the eligibility criteria for MAID and articulated the safeguards necessary to ensure vulnerable persons were adequately protected.

- The eligibility criteria included the requirement that patients be suffering from a grievous and irremediable medical condition, meaning that:
    - They have a serious or incurable illness, disease, or disability;
    - They are in an advanced state of irreversible decline in capability;
    - Their illness, disease, disability, or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions they consider acceptable; and
    - Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances.

- In addition to these eligibility criteria, procedural safeguards were put in place to protect vulnerable persons. This includes the requirements that: a request for MAID be made in writing, signed and dated before two independent witnesses; 10 clear days of reflection pass between the request and provision of MAID; and consent be re-obtained immediately prior to the provision of MAID.

- Importantly, the reasonably foreseeable natural death (RFND) requirement was the subject of significant debate at the time the legislation was enacted, due to its ambiguity and to the question of whether this requirement was consistent with the *Carter* decision.

- The legislation also included a commitment to conduct a full parliamentary review of the law to allow for further public and parliamentary debate starting in the summer of 2020.

CURRENT STATUS:

A. The *Truchon* Decision

- On September 11, 2019 the Superior Court of Quebec struck down the RFND eligibility requirement on the basis that it violated the *Charter* rights of individuals by denying all non-dying persons the ability to access MAID. More specifically, the Court found that:

    - Denying these individuals access to MAID forced them to experience prolonged suffering or resort to more degrading or violent means of death.

    - The RFND requirement was overbroad in its application and that the other eligibility criteria were sufficient to protect vulnerable persons.

    - The RFND requirement discriminated against those with a disability not associated with a decline towards death by embodying the stereotype that persons with disabilities are not able to make the “right decision” for themselves.

    - Clinicians are able to: differentiate between suicidal patients and patients seeking MAID; assess risk factors associated with vulnerability; and assess a patient’s capacity to consent to a treatment or procedure.

- The Court invalidated the RFND requirement in the legislation, but suspended the effect of its decision until March 11, 2020 to allow legislators time to respond. While the ruling only applies in Quebec, the federal government has accepted the judgment and has committed to changing the law at the federal level.

B. Federal Consultation

- To support the development of new legislation, the federal government held a public consultation between January 13 and 27, 2020. The consultation focused on the following:

    - Whether additional safeguards are needed if the RFND requirement is removed. Among others, examples of additional potential safeguards include: mandatory psychiatric assessment, mandatory involvement of a specialist relating to the patient's illness, disease, or disability, and an extended reflection period.

    - Whether patients who have been determined eligible and provided consent but lose capacity prior to the provision of MAID should be permitted to access MAID.

    - Whether patients not yet eligible for MAID should be able to set out the conditions under which they would want to receive MAID through an advance directive.

- While the purpose of the consultation was to give individual Canadians the opportunity to provide feedback, the Federation of Medical Regulatory Authorities of Canada (FMRAC) identified a means for providing feedback and quickly coordinated a response through consultation with the Registrars across Canada.

- The submission was intended to respond to the issues of the consultation, but also to address issues that have been identified through our regulatory work. The resulting submission included:

    - Support for removing the RFND requirement without adding any additional eligibility criteria or procedural safeguards.

    - Support for removing the requirement for two independent witnesses as this has compromised access and infringes on patients' right to privacy.

    - Support for allowing the provision of MAID to patients who have lost capacity after having been found eligible for and providing consent to MAID.

    - A proposal to defer the broader question of advance directives.

    - Support for including language clarifying that informing patients about MAID is not counselling patients for MAID.

    - Support for expressly permitting patients to provide consent to either or both modes of administering MAID (i.e., self-administered or clinician-administered), thereby clearly permitting clinicians to intervene and provide MAID should a self-administered attempt at MAID fail.

C. Federal Ministers' Roundtable on MAID

- The College was invited to attend a Federal Ministers' Roundtable on MAID to engage in a discussion with key stakeholders on the core issues of the consultation. Participants included FMRAC, Canadian Medical Protective Association, Canadian Bar Association, individuals representing nursing, social work, and special populations (e.g., women with disabilities, Indigenous peoples), and palliative care physicians and nurse practitioners.

- The discussion was thoughtful, and a diversity of perspectives was shared.

    - In general, there was agreement that access to palliative care needs to improve and there were expressions of concern regarding expanding access and the need to protect vulnerable populations.

    - There was also general agreement that patients deemed eligible and who have provided consent should be able to receive MAID if they lose capacity, but that the broader issue of advance directives should be tabled for further discussion.

- The College's contribution was informed by the FMRAC submission as well as previous College submissions on this issue, focusing on support for reasonable and fair access. Comments provided include:

    - An echo of support for the FMRAC submission, including the importance of permitting physicians to intervene where a self-administered attempt fails.

    - Identifying the importance of ensuring the legislative framework is compliant with the *Carter* decision regarding eligibility and access.

    - Highlighting the risk that new safeguards may simply re-embed the elements of the current system which were found to be discriminatory in the *Truchon* decision at a different level within the framework.

    - Raising concerns regarding access if new safeguards are introduced and applied to all persons seeking MAID, and practical challenges that would arise if two sets of safeguards are applied depending on whether or not the RFND requirement is satisfied (i.e., the difficulty of clearly demarcating the line between these groups).

NEXT STEPS:

- Given the March 11, 2020 deadline it is anticipated that the next steps of the legislative process will unfold quickly. As of the Council submission deadline, staff are not aware of any additional public announcements that have been made regarding the legislation.

- Should new legislation be in place, the current *Medical Assistance in Dying* policy will be quickly amended to reflect the new regime with a further, more comprehensive review of the policy set to happen later this year.

DISCUSSION FOR COUNCIL:

This item is for information

Contact: Craig Roxborough, Ext. 339
Date: February 13, 2020

Council Motion

Motion to withdraw

Date of Meeting: March 6, 2020

Whereas, at the December 2019 Council meeting, a motion was made to discuss a motion at the March 2020 meeting as set out below.

And whereas the mover of the December 2019 motion wishes to withdraw that motion,

It is moved by Dr. Berger, and seconded by_____, that:

The following motion be withdrawn:

> **Motion Title: Retaining an external expert to make recommendations to Council on upholding the CPSO's independence and the CPSO's primary duty to serve and protect the public interest**
>
> It is moved by _____
>
> and seconded by_____that:
>
> The Council directs that the CPSO Executive Committee retain within 1 month of Council's approval of this motion an external expert from either the Judiciary or the Bar to make and deliver to Council, within 6 months of Council's approval of this motion, recommendations on the CPSO deliberative processes respecting patient care; the recommendations to include the following:
>
> 1) Guidelines to guarantee the independent gathering, with appropriate thoroughness, of reliable information from all relevant sources and of opinion from all relevant parties;

2) Guidelines on how to appropriately and transparently weigh that information and opinion in the course of the CPSO deliberative processes;

3) Guidelines to forestall any undue influence, apparent or real, of any party external to the CPSO so that the transparency and independence of the CPSO are upheld; and

4) General advice on sustaining the CPSO's primary duty to serve and protect the public interest

CPSO Relationship with Health System Stakeholders

(no materials)

Council Motion

Motion Title: Fees and Remuneration By-law Amendment

Date of Meeting: March ___, 2020

It is moved by_____,

and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 132.

By-law No. 132

(1) Sections 14, 15 and 16 of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked.

Council Briefing Note

March 2020

TOPIC: Fees and Remuneration By-Law

FOR DECISION

ISSUE:

Approval of the Fees and Remuneration By-law

BACKGROUND:

At the Council meeting in December of 2019, Council proposed to make changes to the Fees and Remuneration By-Law.

This change involved eliminating several of the fees that the College was charging for including:

- Certificates of Professional Conduct
- Wall Diplomas
- Embassy Letter's
- Use of the College Seal

As required, the by-law was circulated to the profession and is now coming back for final approval.

NEXT STEPS:

Council Approval.

DECISION FOR COUNCIL:

Does Council approve the Fees and Remuneration By-law?

Contact: Nathalie Novak, ext. 432
Douglas Anderson, ext. 607
Leslee Frampton, ext. 311.

Date: February 7, 2020

Attachment: Council Motion

Council Motion

Motion Title: By-law Amendment – election recounts

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 134:

By-law No. 134

(1) Section 21 of the General By-law is revoked and the following is substituted:

Recounts

21. (1) A candidate may require a recount by giving a written request to the registrar no more than three business days after the date of an election and paying a fee of $500.

(2) The registrar shall hold the recount no more than thirty days after receiving the request.

CPSO

Council Briefing Note

March 2020

TOPIC: Council Election Recount Request Period

FOR DECISION

ISSUE:

- Council is being asked to approve by-law amendments to shorten the period for requesting a recount of the results of Council elections.

BACKGROUND:

- The By-laws currently provide for a 14-day period in which any candidate in a district Council election may request a recount.
- A proposal to shorten the period for requesting a recount to three business days was brought to Council in December. This would enable earlier communication of the official results.
- Council approved circulation of the proposed by-law amendments in December.
- The proposed by-law amendments were circulated to the profession as required by the Regulated Health Professions Act (RHPA). No comments were received.

NEXT STEPS:

- Executive Committee approved forwarding the proposed by-law amendments to Council for final approval.

DECISION FOR COUNCIL:

1. Does Council approve the proposed by-law amendments to shorten the period for requesting a recount for Council elections from 14 days to 3 business days?

Contact: Laurie Cabanas, 503
Marcia Cooper, 546

Date: February 7, 2020

Council Motion

Motion Title: Committee Appointments

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

1. The Council of the College of Physicians and Surgeons of Ontario appoints _____, (as Vice President) to the Governance Committee for the remainder of the 2020 Council year.

2. The Council of the College of Physicians and Surgeons of Ontario appoints _____, (as Vice President) to the Finance and Audit Committee for the remainder of the 2020 Council year.

CPSO

Council Briefing Note

March 2020

TOPIC: **Governance Committee Report:**

- **Committee Appointments**

FOR DECISION

Committee Appointments

ISSUE:

- As a result of the election for Vice President, Council may be asked to make consequential and additional committee appointments at the March 6, 2020 Council meeting.

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, 503
Marcia Cooper, 546
Debbie McLaren, 371

Date: February 13, 2020

CPSO

Council Motion

Motion Title: Committee Appointments

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

1. The Council appoints the following people to the following committees until the Annual General Meeting of Council in December, 2020:

    Discipline Committee:

Mr. Jose Cordeiro	(public member)
Ms. Linda Robbins	(public member)

    Inquiries, Complaints and Reports Committee:

Ms. Nadia Joseph	(public member)
Dr. Lydia Miljan, PhD	(public member)
Dr. Elizabeth Samson	(physician Council member)

2. The Council appoints Dr. Judith Plante as Chair of the Registration Committee.

3. The Council appoints Dr. Anita Rachlis as Vice Chair, Internal Medicine Panels of the Inquiries, Complaints and Reports Committee.

CPSO

Council Briefing Note

March 2020

TOPIC: Committee and Chair Appointments

ICR Committee:
Ms. Nadia Joseph, *(new public member)*
Dr. Lydia Miljan, *PhD*, *(new public member)*
Dr. Elizabeth Samson *(Council member)*
Dr. Anita Rachlis *(Non-council committee member)*, Vice Chair, Internal Medicine Panels

Discipline Committee:
Mr. Jose Cordeiro, *(new public member)*
Ms. Linda Robbins, *(new public member)*

Registration Committee:
Dr. Judith Plante *(Council member)* Chair

FOR DECISION

ISSUE:

- Council will consider committee and chair recommendations made by the Governance Committee on February 24, 2020:

ICR Committee:	Ms. Nadia Joseph
	Dr. Lydia Miljan, *PhD*
	Dr. Elizabeth Samson
	Dr. Anita Rachlis, Vice Chair, ICRC Internal Medicine Panels
Discipline Committee:	Mr. Jose Cordeiro
	Ms. Linda Robbins
Registration Committee:	Dr. Judith Plante, Chair

BACKGROUND:

Committee Appointments:

- There is an urgent need for public members to be appointed to both the Discipline Committee and the ICR Committee.
- The Committee recommended two new public members for appointment to the ICR Committee; Ms. Nadia Joseph and Dr. Lydia Miljan, *PhD,* and two new public members for appointment to the Discipline Committee; Mr. Jose Cordeiro and Ms. Linda Robbins.
- The Governance Committee also recommended Dr. Elizabeth Samson for appointment to ICR Committee.

Chair Appointments:

- With the departure of Dr. Akbar Panju from Council, there is a vacancy for a Vice Chair, ICRC, Internal Medicine Panels and Chair for the Registration Committee.
- The Governance Committee recommends Dr. Anita Rachlis for Vice Chair, ICR Committee, Internal Medicine Panels, and Dr. Judith Plante for Chair, Registration Committee.
- In her role (on ICRC) as mentor to new ICRC members/Vice Chairs, Dr. Carol Leet will mentor Dr. Rachlis in her new role as Vice Chair.

On February 27, 2020, the Executive Committee** met to review and discuss the Governance Committee's recommendations and is forwarding to Council for final approval.

DECISION:

1. Appoint Ms. Nadia Joseph, Dr. Lydia Miljan, *PhD*, and Dr. Elizabeth Samson to the ICR Committee for appointment for a one-year term*.
2. Appoint Mr. Jose Cordeiro and Ms. Linda Robbins to the Discipline Committee for appointment for a one-year term*.
3. Appoint Dr. Judith Plante as Chair, Registration Committee for a one-year term*.
4. Appoint Dr. Anita Rachlis as Vice Chair, ICR Committee, Internal Medicine Panels for a one-year term*.

(* All one-year committee/chair term appointments will terminate on December 4, 2020 at the annual general meeting of Council).
(**At the February 27, 2020 Executive Committee meeting, Dr. Judith Plante abstained from her appointment.)

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Debbie McLaren, ext. 371
Date: February 27, 2020

Council Motion

Motion Title: Exceptional Circumstances

Date of Meeting: March 6, 2020

It is moved by_____,

and seconded by_____, that:

1. The Council approves, in principle, that the exceptional circumstances clause in Section 37(8) of the General By-law be applied in respect of the following members of the committees listed below when their appointments expire at the Annual General Meeting of Council in December 2020:

Inquiries, Complaints and Reports Committee

Dr. Stephen Whittaker
Dr. Anil Chopra
Dr. Haig Basmajian
Dr. Robert Hollenberg

Registration Committee

Dr. Bob Byrick
Dr. Barbara Lent

Discipline Committee

Dr. Pamela Chart

Dr. Melinda Davie

Dr. Robert Sheppard

Dr. Eric Stanton

Dr. Dennis Pitt

Dr. Steven Bodley

Fitness to Practise Committee

Dr. Steven Bodley

CPSO

Council Briefing Note

March 2020

TOPIC: Committee Requests for Exceptional Circumstances

FOR DECISION

ISSUE:

- The Council is asked to consider, in principle, that the exceptional circumstances clause in Section 37(8) of the General By-Law be applied to 13 Committee members when their appointment term ends at the Annual General Meeting of Council in December 2020.

BACKGROUND:

- In September 2019. Council approved the introduction of term limits to Committees to reflect good governance practices.

- The General By-Law specifies that a person is not eligible for appointment to a Committee if the person has been a member of that Committee for a total of nine years or more, whether consecutively or non-consecutively.

- Furthermore, a person is not eligible for appointment to a Committee if the member has been a Council member or a member of any one or more Committees for a total of 18 years or more, whether consecutively or non-consecutively.

- To ensure that Committees and Council are not destabilized by the changes, Council approved a provision to allow a particular member's appointment to exceed applicable term limits. Reasons where a Committee may request to use the provision include but are not limited to:
    - a member is very experienced compared to other Committee members and is critical to maintaining stability and promoting effective functioning of the Committee;
    - a member's expertise is providing difficult to replace; and
    - a member requires leave for a sudden illness or very unexpected personal reasons.

CURRENT STATUS:

- Committee Chairs/Co-Chairs submitted 13 requests for Exceptional Circumstances to the Governance Committee.

- The Governance and Executive Committees met on February 24, 2020 and considered and determined that the rationale provided in these requests are appropriate.

- As this is the first year of using the Exceptional Circumstances provision, the Governance Committee recommends that any requests that are approved be for one year at a time (i.e. until December 2021).

DECISION FOR COUNCIL:

The Council is asked to approve, in principle, that the exceptional circumstances clause in Section 37(8) of the General By-law be applied in respect of the following members of the Committees listed below when their appointments expire at the Annual General Meeting of Council in December 2020:

Inquiries, Complaints and Reports Committee:

- Dr. Stephen Whittaker
- Dr. Anil Chopra
- Dr. Haig Basmajian
- Dr. Robert Hollenberg

Registration Committee:

- Dr. Bob Byrick
- Dr. Barbara Lent

Discipline Committee:

- Dr. Pamela Chart
- Dr. Melinda Davie
- Dr. Robert Sheppard
- Dr. Eric Stanton
- Dr. Dennis Pitt
- Dr. Steven Bodley

Fitness to Practise Committee:

- Dr. Steven Bodley

Contact: Dr. Peeter Poldre, Chair, Governance Committee
Laurie Cabanas, ext. 503
Suzanne Mascarenhas, ext. 843

Date: February 27, 2020