CPSO

Meeting of Council

Annual Financial Meeting

June 16 & 17, 2022

NOTICE

OF

MEETING OF COUNCIL

A meeting of the Council of the College of Physicians and Surgeons of Ontario (CPSO) will take place in-person on June 16 and 17, 2022 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario. This meeting is the annual financial meeting of Council. At this time, the in-person meeting will be limited to Council members, invitees and staff members.

The meeting will be streamed live. Members of the public who wish to observe the meeting can register on CPSO's website using the online registration. Instructions for accessing the meeting will be sent to those who have registered.

The meeting will convene at 9:00 am on Thursday, June 16, 2022.

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

June 1, 2022

Council Meeting Agenda
Annual Financial Meeting
June 16-17, 2022

CPSO

THURSDAY, JUNE 16, 2022

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am** (30 mins)	**INFORMAL NETWORKING** (Breakfast available in the Dining Room)		
1	**9:00 am** (10 mins)	**Call to Order and Welcoming Remarks** (J. van Vlymen) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
2	**9:10 am** (5 mins)	**Consent Agenda** (J. van Vlymen) 2.1 Approve Council meeting agenda 2.2 Approve draft minutes from Council meeting held on March 3-4, 2022	Approval (with motion)	1-23
3	**9:15 am** (5 mins)	**Items for information:** 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Finance and Audit Committee Report 3.5 Policy Report 3.6 Medical Learners Report 3.7 Update on Council Action Items	Information	 24 25-29 30 31-35 36-39 40-47
4	**9:20 am** (60 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
5	**10:20 am** (15 mins)	**President's Report** (J. van Vlymen)	Discussion	N/A
*	**10:35 am** (20 mins)	**NUTRITION BREAK**		
6	**10:55 am** (30 mins)	**Dispensing Drugs – Draft Policy for Consultation** (A. Wong) • Consider approving the draft Dispensing Drugs policy for external consultation	Decision (with motion)	48-57
7	**11:25 am** (10 mins)	**Governance Committee Report** (J. Plante) 7.1 Update on Council Elections	Information	58-59

Item	Time	Topic and Objective(s)	Purpose	Page No.
8	**11:35 am** (10 mins)	**Register By-law Amendments** (M. Cooper) • Feedback from the external consultation is provided to Council. Council is asked to approve the Register By-law amendments	Decision (with motion)	60-66
9	**11:45 am** (15 mins)	**COUNCIL AWARD PRESENTATION** (Dr. Deborah Robertson) Celebrate the achievements of Dr. Sinziana Avramescu, Toronto		
*	**12:00 pm** (60 mins)	**LUNCH**		
10	**1:00 pm** (60 mins)	**The Power of Teamwork** (Dr. Brian Goldman)	Information	N/A
11	**2:00 pm** (40 mins)	**Finance and Audit Committee Update** (T. Bertoia, D. Anderson, N. Novak, Tinkham LLP) **11.1 Audited Financial Statements for the 2021 Year**		67-85
		11.2 Approval of the Audited Financial Statements for the fiscal year ended December 31, 2021 (N. Novak)	Decision (with motion)	86
		11.3 Appointment of the Auditor for 2022 fiscal year	Decision (with motion)	87
		11.4 Fees By-law Update (D. Anderson) • Consider by-law amendments to reflect changes to travel time for Council and Committee Members	Decision (with motion)	88-94
*	**2:40 pm** (20 mins)	**BREAK**		
12	**3:00 pm** (45 mins)	**Decision-Making for End-of-Life Care – Draft Policy for Consultation** (L. Kirshin, R. Bernstein) • Consider approving the draft Decision-Making for End-of-Life Care policy for external consultation	Decision (with motion)	95-117
13	**3:45 pm** (15 mins)	**Proposed Amendments to Medical Records Management Policy** (T. Terzis) • Consider approving the proposed amendments to the Medical Records Management Policy	Decision (with motion)	118-140
14	**4:00 pm**	**Adjournment Day 1** (J. van Vlymen)	N/A	N/A

FRIDAY, JUNE 17, 2022

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING**		
15	**9:00 am** (10 mins)	**Call to Order** (J. van Vlymen) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
16	**9:10 am** (40 mins)	**Virtual Care – Revised Policy for Final Approval** (T. Terzis) • Consider approving the Virtual Care policy	Decision (with motion)	141-163
17	**9:50 am**	**Motion to move In-Camera** (J. van Vlymen)	Decision (with Motion)	164
*	**9:50 am** (30 mins)	**NUTRITION BREAK**		
18	**10:20 am** (30 mins)	**In-Camera Session**		
19	**10:50 am** (20 mins)	**Presidential Compensation** (N. Novak, C. Allan) • Consider approving the Fees By-law amendments to reflect changes to the Presidential Compensation	Decision (with motion)	165-171
20	**11:10 am** (45 mins)	**Social Media – Revised Policy for Final Approval** (A. Wong) • Consider approving the Social Media policy	Decision (with motion)	172-190
21	**11:55 am** (5 mins)	**Adjournment Day 2** (J. van Vlymen) • Reminder that the next meeting is scheduled on September 22-23, 2022	N/A	N/A
*	**12:00 pm** (60 mins)	**LUNCH**		

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
March 3 and 4, 2022

Location: Council Chamber, 80 College Street, Toronto, Ontario

March 3, 2022

Attendees

Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Shahid Chaudhry
Dr. Brenda Copps
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton (Vice Chair)
Dr. Deborah Hellyer
Dr. Paul Hendry
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris *(partial)*
Ms. Lydia Miljan
Dr. Rupa Patel
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Janet van Vlymen (Chair)
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. P. Andrea Lum
Dr. Karen Saperson

Regrets:

Mr. Pierre Giroux
Dr. Kashif Pirzada

1. Call to Order and Welcoming Remarks

J. van Vlymen, President of Council and Chair, called the meeting to order at 1:00 pm. J. van Vlymen welcomed members of Council, including M. Azad, the new Council member recently elected in the District 9 By-Election . She also welcomed staff, and members of the public tuning in via YouTube. She reminded the meeting participants of the College's mission, vision and values. J. van Vlymen noted that M. Azad is conflicted from participating and voting on the Committee Appointment (new item) covered under item number 6 – Governance Committee Report. There were no other conflicts of interest declared.

J. Goyal, Public Member on Council delivered the land acknowledgement as a demonstration of recognition and respect for Indigenous peoples of Canada.

J. van Vlymen conducted a roll call and noted regrets from P. Giroux.

2. Consent Agenda

J. van Vlymen provided an overview of the items listed on the Consent Agenda for approval, noting that a new item, Committee Appointment, is coming forward for decision and will be added under item 6 - Governance Committee Report.

01-C-03-2022

The following motion was moved by J. Fisk, seconded by D. Hellyer and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for March 3 & 4, 2022, as amended; and
- The minutes from Council held December 9 & 10, 2021

CARRIED

3. For Information

The following items were included in Council's package for information:

3.1 Executive Committee Report
3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
3.3 Government Relations Report
3.4 Policy Report
3.5 Medical Learners Report
3.6 Update on Council Action Items

4. Chief Executive Officer / Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar presented her report and shared the CPSO's Timeline of Accomplishments for 2020-2022. She shared the strategic wheel and pillars as well as the College's vision. Progress was reported on the 2021 key performance indicators that were approved by Council at the December meeting.

C. Allan was introduced to the meeting as Manager of the Governance Office.

An overview of the Solis and Vault timelines were shared noting that all systems are up and running and doing well. Staff were recognized for their phenomenal work in moving the transformation forward.

Updates were provided on the registration process and annual renewals. An overview was provided on the Quality Improvement program as well as the number of hospitals collaborating in the Quality Improvement partnership. An update was provided on the number of Quality Assessments being conducted on physicians who are 70+ by 22 new assessors.

An update was provided on the Out of Hospital Premises Inspection Program, noting that staff are working on updating the standards and the updated standards will be brought to Council in the Fall for review and feedback.

An update on some legal cases was provided, along with an update on time from referral to discipline and time from disclosure to pre-hearing conference.

Policy consultations have recently resumed following a pause.

An update was provided on engagement and collaboration, noting that the College will be launching a podcast as well as releasing the next issue of eDialogue in the coming weeks. Due to a paper shortage, there is a significant delay in receiving hard copies of eDialogue. Following discussion, staff will examine alternate options regarding future eDialogue issues. Council will be kept apprised of any significant changes.

Council Members provided positive feedback on the timeline of accomplishments.

N. Whitmore noted that Dr. Horton was recently interviewed for the upcoming eDialogue issue and reiterated the importance of keeping the conversation going on physician burnout.

Dr. Marks de Chabris joins the meeting.

5. President's Report

J. van Vlymen presented her President's report to Council reporting on a number of meetings that have taken place over the course of January and February. She reported on a collaborative meeting between the College and the Ontario Medical Association where common interests and themes including physician wellness and various ways to help address burnout were shared. An example of reducing burnout is allowing for flexibility regarding timing for participation in the Quality Improvement program. Supportive messaging from N. Whitmore has been communicated to the profession recognizing challenges.

Various consultations were paused and timelines for such consultations were extended before the holidays in order to alleviate pressures faced by the profession.

Many complaints / concerns are being addressed using the Alternative Dispute Resolution resulting in efficient management of the complaints process and reaching early resolution thereby reducing the amount of time a patient / physician has to wait for an outcome.

An update was provided on the policies coming down the pipeline noting that the Virtual Care Policy and the Social Media Policy will be coming back for final approval.

A number of meetings have occurred with various stakeholders including Members of Provincial Parliament.

The Annual Renewal Process question have been updated to remove redundant questions and eliminate double negatives in order to streamline the process.

Dr. van Vlymen noted that two Council members had raised the possibility of reducing membership fees for humanitarian work. Staff will look into this item.

At the request of the Executive Committee, the Finance Committee is working on addressing confusion surrounding travel expenses, materials will be provided to give guidance to Council / Committee Members.

This year, District elections will take place for Districts 1, 2, 3 and 4, Council Members were encouraged to reach out to potential candidates in their networks to run in the upcoming 2022 District elections.

There will be a communication to Council Members regarding the upcoming Federation of Medical Regulatory Authorities of Canada Conference being held in June. A Physician member and a Public member will be invited to attend. Conference details will be posted by FMRAC at the end of March. Further information will be shared in due course from the Governance Office as soon as the agenda becomes available. The Governance Office will be seeking expressions of interest from those who wish to attend. These will be brought forward to the Governance Committee for decision.

A copy of Dr. Horton's book will be provided to each Council Member via mail.

Council discussed issues surrounding virtual care, the virtual care policy will be coming back to Council for review and decision in due course.

6. Governance Committee Report

J. Plante, Chair of Governance, presented items from the December and January Governance Committee meetings. She recognized N. Novak, C. Roxborough and L. Brownstone for their leadership in moving the work of the Governance Committee forward. An update was provided on the District 9 by-election recently held, noting that 25 percent of eligible voters casted a vote.

An update was provided on the Joint Governance Committee and Executive Committee held prior to today's Council meeting. Both Committees conducted a joint meeting to review and recommend to Council, the appointment of M. Azad to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee which would become effective immediately following approval by Council.

02-C-03-2022

The following motion was moved by R. Kirkpatrick, seconded by L. Becker (with M. Azad abstaining) and carried, that:

> The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Madhu Azad to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practice Committee, effective immediately, for a term ending at the Annual General Meeting of Council 2024.

CARRIED

J. Plante provided the Public Member Update noting that F. Sherman and P. Pielsticker have been re-appointed as Public Members of Council.

An update was provided on Vice-Chair appointments approved by the Executive Committee, P. Cleiman was appointed as Specialty Vice-Chair of the Inquiries Complaints and Reports Committee Family Practice Panel and T. Xenodemetropoulos was appointed as the Premises Inspection Committee Vice-Chair. Both terms are in effect until the Annual General Meeting of Council 2022.

The Governance Committee approved changes to the Terms of Reference noting that the Terms of Reference will no longer require signatures. The Terms of Reference will continue to be reviewed and acknowledged by each Committee at its first business meeting.

Responses received on the Council and Committee Satisfaction surveys were very positive. Staff is in the process of communicating the results and preparing an action plan based on constructive feedback received.

Succession planning is underway for each of the Committees. Such succession plans will be shared with the Committee Chairs and Vice-Chairs.

Efforts are ongoing to continue to examine ways to enhance internal structures to achieve governance modernization goals in the absence of legislative change.

J. Plante noted that Council elections are coming up this Spring and she encouraged physicians in Districts 1, 2, 3 and 4 to run for election. The Governance Committee is looking for opportunities to enhance its work by implementing best governance practices.

7. Proposed By-law Amendments regarding Tribunal References

M. Cooper, Senior Corporate Counsel and Privacy Officer provided an overview of the proposed By-law amendments regarding Tribunal references noting that the name of the Discipline Committee was changed last year to the Ontario Physicians and Surgeons Discipline Tribunal.

03-C-03-2022

The following motion was moved by P. Malette, seconded by J. Rosenblum and carried, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 147:

By-law No. 147

1. Paragraph (a) of subsection 22(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”.

2. Paragraph (a) of subsection 27(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”.

3. Paragraph (a) of subsection 36(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”.

4. Section 40b of the General By-law is amended by adding the following at the end of the section:

   For ease of reference, the Ontario Physicians and Surgeons Discipline Tribunal is referred to in this General By-law by its English name or acronym, and all references to the English name or acronym shall be deemed to equally refer to or apply to its French name or acronym, respectively.

CARRIED

8. By-law Amendments for Reduced Membership Fees for Parental Leaves

M. Cooper, Senior Corporate Counsel and Privacy Officer provided an overview of the proposed By-law amendments regarding Reduced Membership Fees for Parental Leaves noting that the proposed by-law amendments were brought to Council at its December meeting and were circulated to the profession for feedback. No comments were received.

04-C-03-2022

The following motion was moved by A. Walsh, seconded by S. Chaudhry and carried, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 143:

By-law No. 143

(1) Section 4 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

4. Annual fees, as of June 1, 2018, are as follows:

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration;

(b) For a holder of a certificate of registration authorizing postgraduate education applying to renew his/her certificate of registration, 20% of the annual fee set out in

subsection 4(a); and

(c) Notwithstanding subsections 4(a) and (b), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is as follows:

i. 50% of the annual fee set out in subsection 4(a) for holders of a certificate of registration (except as set out in subsection 4(c)(ii)); or

ii. 50% of the annual fee set out in subsection 4(b) for holders of a certificate of registration authorizing postgraduate education,

so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. Where applications for the parental leave reduced annual fee are received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This subsection 4(c) only applies to annual fees for membership years commencing on or after June 1, 2020.

(2) Section 4.1 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

4.1 Annual fees for a holder of a certificate of authorization, as of January 1, 2017, are $175.

CARRIED

9. Proposed Register By-law Amendments

M. Cooper, Senior Corporate Counsel and Privacy Officer provided an overview of proposed By-law Amendments relating to the Register noting that such amendments will be required to be circulated to the profession. Council Members were given the opportunity to ask questions and seek clarification on the register amendments. Following discussion, Council expressed their support for circulating the proposed Register by-law amendments, as presented, to the profession.

05-C-03-2022

The following motion was moved by J. Fisk, seconded by L. Miljan and carried, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 148, after circulation to stakeholders:

By-law No. 148

(1) Paragraphs 12, 13, 14, 17 and 17.1 of subsection 49(1) of the General By-law are revoked and substituted with the following:

12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations and relinquishments of the member's privileges or practice, and rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect.

13. If an allegation of professional misconduct or incompetence against the member has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided,
    i. a summary of the allegation if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to September 10, 2013,
    ii. a summary of the allegation and/or the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal after September 10, 2013,
    iii. an indication that the matter has been referred to the Ontario Physicians and Surgeons Discipline Tribunal,
    iv. the anticipated date of the hearing, if the date has been set,
    v. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of the adjournment, and
    vi. if the decision is under reserve, that fact.

14. If the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register,
    i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding,
    ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty, and
    iii. if the finding is appealed, the status of the appeal and the disposition of the appeal.

17. If an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal,
    i. that fact,
    ii. the dates on which the application is scheduled to be heard,
    iii. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of that adjournment, and
    iv. if the decision is under reserve, that fact.

17.1 If an application to the Ontario Physicians and Surgeons Discipline Tribunal for reinstatement has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

(2) The following are added as paragraphs 17.3 and 17.4 of subsection 49(1) of the General By-law:

17.3 If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed,

i. that fact,
ii. the dates on which the application is scheduled to be heard,
iii. if the hearing has been adjourned and no future date has been set, the fact of that adjournment, and
iv. if the decision is under reserve, that fact.

17.4 If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

CARRIED

10. Adjournment Day 1

J. van Vlymen adjourned day 1 of the Council meeting at 4:00 pm.

Draft Proceedings of Council – March 4, 2022

Attendees

Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Shahid Chaudhry
Dr. Brenda Copps
Mr. Jose Cordeiro
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton (Vice Chair)
Dr. Deborah Hellyer
Dr. Paul Hendry
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Ms. Lydia Miljan
Dr. Rupa Patel
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Janet van Vlymen (Chair)
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. P. Andrea Lum
Dr. Karen Saperson

Regrets:

Mr. Pierre Giroux
Dr. Kashif Pirzada

11. Call to Order

J. van Vlymen, Chair and President, called the meeting to order at 9:00 am and welcomed everyone back to the meeting. A roll call was conducted.

12. Council Education Presentation – Dr. Jillian Horton

J. van Vlymen introduced Council's guest speaker, Dr. Jillian Horton. Dr. Horton delivered a poignant presentation on the topic of Physician Burnout sharing her experience with physician burnout.

13. Medical Psychotherapy Association of Canada Third Pathway

D. Bowlby provided an overview on the Medical Psychotherapy Association of Canada Third Pathway. Council supported extending the status of the Medical Psychotherapy Association of Canada as a "third pathway" of continuing professional development until September 2024.

06-C-03-2022

The following motion was moved by I. Preyra, seconded by J. Goyal and carried, that:

The Council of the College of Physicians and Surgeons of Ontario extends the status of the Medical Psychotherapy Association of Canada as a third pathway of Continuing Professional Development (CPD) until September 2024.

CARRIED

14. College Performance Measurement Framework

H. Webb provided an overview of the College Performance Measurement Framework (CPMF). Council was given an opportunity to ask questions on the CPMF. Council acknowledged that they have had an opportunity to review the CPMF and supported posting the CPMF on the CPSO website and submitting the same to the Ministry of Health by March 31, 2022.

15. Council Award Presentation

I. Preyra, Council Member presented the Council Award to Dr. Alim Pardhan of Hamilton for his leadership in teaching medical residents at Hamilton Health Sciences. Dr. Pardhan was recognized for his work as an emergency physician providing exemplary care to patients as well as being actively engaged in teaching medical residents. Dr. Pardhan expressed appreciation to the CPSO for recognition of his outstanding contributions to the profession.

16. Governance Modernization – Update on Internal Reforms

C. Roxborough, Director, Policy provided an overview and background on Governance Modernization - Update on internal reforms. Staff are looking at exploring options to advance the College's governance structure within the current existing legislation.

Focused around the three key pillars of previous submissions to government, Council was provided with an overview of how reforms could be enacted within the existing legislative framework that would help make progress towards (i) reducing the size of Council (ii) adopting a competency-based appointment process for Council members and (iii) separating the membership of Council and member specific issue statutory committees.

More specifically: reducing the size of Council to the legislative minimums; amending election eligibility criteria, enhancing the Council competency framework, and implementing a Nominating Committee to support the election process; and formalizing the current practice of limiting Council Member appointments where there are no statutory requirements.

Council was given an opportunity to ask questions and provide feedback regarding the options presented to support internal governance reform. Staff will work on developing options to achieve these reforms and will bring more proposals back to Council at future meetings to explore proposals in detail.

17. Rescinding and Revising Registration Policies - Post MCCQE2 Changes

S. Tulipano, Director, Registration and Membership Services provided an overview of proposed changes to Registration policies in response to the recent sunsetting of the MCCQE2 examination. Following questions and discussion, Council expressed support regarding the proposed changes to the Registration Policies and the rescission of two Registration Policies as outlined in the briefing note to reflect the post MCCQE2 changes.

07-C-03-2022

The following motion was moved by D. Hellyer, seconded by J. Plante and carried, that:

1. The Council of the College of Physicians and Surgeons of Ontario approves the following:

    (a) The revised policy “Restricted Certificate of Registration for Exam Eligible Candidates”, (a copy of which forms Appendix “A“ to the minutes of this meeting);

    (b) The revised policy “Recognition of Certification Without Examination Issued by the CFPC” (a copy of which forms Appendix “B” to the minutes of this meeting);

    (c) The revised Directive, Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for “Residents Working Additional Hours for Pay” (a copy of which forms Appendix “C“ to the minutes of this meeting);

    (d) The revised Directive, Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for “Camp Doctors” (a copy of which forms Appendix “D” to the minutes of this meeting); and

    (e) The Specific Direction to the Registrar from the Registration Committee – Licentiate of the Medical Council of Canada (LMCC) Policy (a copy of which forms Appendix “E” to the minutes of this meeting).

2. The Council of the College of Physicians and Surgeons of Ontario rescinds the following Registration Policies:

   (a) “Requirement for the Successful Completion of the MCCQE 2- Pandemic Exemption” (a copy of which forms Appendix “F“ to the minutes of this meeting); and

   (b) “Alternative to the MCCQE 2 Examination” (a copy of which forms Appendix “G” to the minutes of this meeting).

CARRIED

18. Motion to Go in Camera

The following motion was moved by C. Lemieux, seconded by S. Weber and carried, that:

08-C-03-2022

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

CARRIED

19. In-Camera Items

Council entered into an in-camera session at 2:20pm and returned to the open session at 2:55 pm.

20. Adjournment Day 2

J. van Vlymen adjourned day 2 of the meeting at 2:55pm.

Chair

Recording Secretary

Appendix A

RESTRICTED CERTIFICATE OF REGISTRATION FOR EXAM ELIGIBLE CANDIDATES

The CPSO can issue a time-limited, restricted certificate of registration to physicians. This certificate is for those who are missing Medical Council of Canada Qualifying Examination (MCCQE) Parts 1 and 2/LMCC, and/or Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada (CFPC) certification, but are officially eligible to take these exams. You may be issued a restricted certificate if you have provided proof that you:

1. have completed the certification exam of the RCPSC or the CFPC, but you have not yet completed parts 1 and 2/obtained the LMCC of the MCCQE, or
2. are currently eligible *without pre-condition* to take the RCPSC or CFPC certification exam. You may or may not have yet completed Parts 1 & 2/obtained the LMCC of the MCCQE.

This restricted certificate is subject to the following conditions:

1. You must practice with a supervisor until you have completed all outstanding exams.
2. Your restricted certificate will expire within a reasonable number of years, not to exceed three years from the date it is issued, if:
    a. you do not successfully complete all outstanding MCC examinations/obtain the LMCC; and
    b. you do not receive certification by exam by either the RCPSC or by the CFPC.

Only in exceptional circumstances will we consider candidates for a renewal of their restricted certificate of registration after the expiration date.

Appendix B

RECOGNITION OF CERTIFICATION WITHOUT EXAMINATION ISSUED BY CFPC

There are two scenarios in which the CPSO will recognize your certification in lieu of a CFPC examination. They are:

1. **Certification without examination and completed an acceptable qualifying exam:**

   You may be issued a **restricted certificate** of registration if you have a medical degree from an acceptable medical school and have:

   1. Successfully obtained certification without examination by the CFPC; and
   2. Successfully completed an **acceptable qualifying examination** as defined in the College's Policy on Acceptable Qualifying Examinations.

   The following conditions will be placed on the certificate:

   3. You must practice with a mentor and/or supervisor until you have successfully completed an assessment.
   4. You must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but we may renew it, with or without additional or other terms, conditions and limitations.

2. **Certification without examination and completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination** or obtained the LMCC**:**

   We may issue you a certificate of registration authorizing **independent practice** if you have a medical degree from an acceptable medical school and have:

   1. Successfully obtained certification without examination by the CFPC; and
   2. Successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination or obtained the LMCC.

Appendix C

Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for "Residents Working Additional Hours for Pay"

In accordance with the "Residents Working Additional Hours for Pay" policy approved by Council on December 10, 2010, where an applicant meets the following conditions:

1. The applicant currently holds an unrestricted certificate of registration authorizing postgraduate education;

2. The applicant has successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination/obtained the LMCC.

3. The applicant has provided a current letter of appointment confirming enrollment in a postgraduate program at an Ontario medical school for the period in which the applicant is seeking to work additional hours for pay.

4. The applicant has successful completed at least 18 months of residency training in one of the following programs in the specified Ontario Medical School below:

    a. University of Toronto: anesthesiology, emergency medicine, endocrinology, internal medicine, ophthalmology, paediatrics, physical medicine and rehabilitation, psychiatry, surgery – cardiac, surgery – general, surgery – orthopaedic, surgery – plastic, urology;
    b. McMaster University: anesthesiology, cardiology, clinical allergy and immunology, critical care, emergency medicine, ENT, endocrinology, internal medicine, general internal medicine, nephrology, paediatrics, developmental paediatrics, psychiatry, surgery – cardiac, surgery – neurosurgery, surgery – plastic, surgery – vascular;
    c. Queen's University: anesthesiology, critical care, emergency medicine, internal medicine, pediatrics, psychiatry, respirology, surgery – general, surgery – orthopaedic;
    d. University of Western Ontario: adult critical care, anesthesiology, emergency medicine, psychiatry, radiology;
    e. University of Ottawa: adult critical care, anesthesiology, emergency medicine, internal medicine, medical oncology, neurosurgery, paediatrics, paediatric infectious diseases, psychiatry, radiology, surgery – cardiac, urology;

5. The Restricted Registration Office at the Ontario Medical School has provided the College directly with an approved application

6. The applicant has completed all requirements of the College application

7. The applicant provides evidence of CMPA Coverage (Class: Moonlighting 14).

8. The applicant provides a signed Undertaking from the Supervising Physician.

9. The applicant satisfies all other registration requirements, including non-exemptible registration requirements, for a postgraduate certificate of registration.

The Registration Committee approves the Registrar imposing the following terms, conditions and limitations on the applicant's certificate of registration:

Practice Outside the Postgraduate Medical Education Program

Dr. [ ] may practise medicine in the following settings:

(a) DEPARTMENT and to the extent of THEIR employment at HOSPITAL, while under supervision coordinated by a supervisor acceptable to the College.

(b) In Dr. [ ] 's practice specified above, Dr. [ ] may not charge a fee for medical services.

Termination of Practice Outside the Postgraduate Medical Education Program

This certificate automatically converts to a regular Postgraduate Education certificate and Dr. [ ] must immediately cease all practice outside the postgraduate medical education program if any one of the following occurs:

(a) the supervisors identified above notify the College of any concerns regarding Dr. [ ] 's practice, including but not limited to concerns regarding knowledge, skill, judgment or attitude;

(b) the supervisor(s) are no longer able or willing to continue to supervise Dr. [ ] 's practice;

(c) the Postgraduate Dean informs the College that the medical school's approval for Dr. [ ] to engage in practice outside the postgraduate medical education program has been withdrawn;

(d) when Dr. [ ] 's employment as specified above ceases; or

(e) if Dr. [ ] takes a leave of absence, or transfers to another program, from the postgraduate education program specified in paragraph (1).

Resumption of Practice Outside the Postgraduate Medical Education Program

In the event of conversion to a regular Postgraduate Education certificate) or expiry of the certificate Dr. [ ] may not resume any practice outside the postgraduate medical education program under the restricted registration for residents policy until Dr. [ ] applies for a new certificate of registration and obtains approval by the Registration Committee.

Appendix D

Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for "Camp Doctors"

In accordance with the "Camp Doctors" Policy approved by the Registration Committee in November 1997, where an applicant meets the following conditions:

1. The applicant has successfully completed Parts 1 & 2 of the Medical Council of Canada Qualifying Examination/obtained the LMCC or an acceptable alternative under the Ontario Regulation;

2. The applicant has obtained certification by examination from the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada;

3. The chief administrator/operator of the camp where the physician will be practising provides a letter that:

    a. Identifies the camp and confirms its not-for-profit/charitable status;
    b. Confirms the applicant's appointment as a camp doctor on a voluntary basis;
    c. Confirms the exact dates of the appointment;
    d. And indicates the nature and scope of services the physician will be expected to provide;

4. The applicant has completed all requirements of the College application;

5. The applicant satisfies all other registration requirements, including non-exemptible registration requirements, for an independent practice certificate of registration.

The Registration Committee approves the Registrar imposing the following terms, conditions and limitations on the applicant's certificate of registration:

1. Dr. [ ] may practice medicine only as a Camp Doctor for NAME OF CAMP in CITY, Ontario.

2. The certificate is issued for the term of [START DATE], to [END DATE].

Appendix E

SPECIFIC DIRECTION TO THE REGISTRAR FROM THE REGISTRATION COMMITTEE

Licentiate of the Medical Council of Canada (LMCC) Policy

Ontario Regulation 856/93 made under the Medicine Act, 1991 (the "Registration Regulation") sets out the standards and qualifications for a certificate of registration authorizing independent practice as including:

3. (1) The standards and qualifications for a certificate of registration authorizing independent practice are as follow:

1. The application must have a degree in medicine.
2. The applicant must have successful completed Part 1 and Part 2 of the Medical Council of Canada Qualifying Examination.
3. The applicant must have completed one of the following:
    I. A clerkship at an accredited medical school in Canada which meets the criteria of a clerkship in clause (a) of the definition of "degree in medicine" in section 1.
    II. A year of postgraduate medical education at an accredited medical school in Canada.
    III. A year of active medical practice in Canada which includes significant clinical experience pertinent to the applicant's area of medical practice.
4. The applicant must have certification by examination by the Royal College of Physicians and Surgeons of Canada or by the College of Family Physicians of Canada

In accordance with the Licentiate of the Medical Council of Canada (LMCC) policy approved by Council on October 14, 2021, the Registration Committee considers *Section 3(1)2 of the Registration Regulation* to be satisfied if:

(a) The applicant demonstrates that they have obtained the Licentiate of the Medical Council of Canada (LMCC) qualification, and
(b) The applicant satisfies all other registration requirements, including non-exemptible registration requirements, for an independent practice certificate.

Appendix F

REQUIREMENT FOR SUCCESSFUL COMPLETION OF PART 2 OF THE MCCQE — PANDEMIC EXEMPTION

Update Regarding MCCQE Part II

The Medical Council of Canada (MCC) announced on June 10, 2021 going forward.

CPSO is immediately examining the implications of this announcement on all affected physicians and is in the process of developing a policy that will be finalized on a future date. Please continue to monitor the website for updates from the College.

The standards and qualifications for the issuance of a certificate of registration authorizing independent practice, set out in Section 3 of *Ontario Regulation 865/93*, stipulate that the applicant must have:

1. A degree in medicine.
2. Successfully completed Part 1 and Part 2 of the Medical Council of Canada Qualifying Examination.
3. Completed a clerkship at an accredited medical school in Canada; or one year of postgraduate medical education at an accredited medical school in Canada; or one year of active medical practice in Canada.
4. Certification by examination by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC); and

Part 2 of the Medical Council of Canada Qualifying Examination (known as “MCCQE2”) is a clinical examination administered by the Medical Council of Canada, which is challenged in locations across Canada, typically after completion of 12 months of postgraduate training.

The MCCQE2 is important as a reliable, independent and objective method of assessment of an applicant’s broad-based medical knowledge, skills, judgment and professional attitude.

Due to the pandemic, MCCQE2 examinations scheduled for May 2020 and October 2020 were postponed indefinitely. Applicants in Ontario who otherwise qualified for Independent Practice Certificates but were lacking MCCQE2 were issued restricted certificates permitting practice under supervision in accordance with the Restricted Certificates of Registration for Exam Eligible Candidates.

The MCCQE2 examination scheduled for February 2021 has been cancelled. At this time, it is not clear when the MCCQE2 exam will be made available to eligible candidates.

This Policy provides an exception to the licensure requirement for the MCCQE2 for applicants whose pathway to independent licensure in Ontario has stalled due to the pandemic-related postponements of the examination in circumstances set out below.

MCCQE2 Pandemic Exemption

The Registration Committee may direct the Registrar to issue a certificate of registration authorizing **independent practice** to applicants who are lacking MCCQE2 where:

1. The applicant demonstrates that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings*;
2. The applicant is presently registered in Ontario or was registered in Ontario at the time that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings;
3. The applicant was within 24 months from the completion of their postgraduate training at the time that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings;
4. The applicant otherwise meets the prescribed requirements for an Independent Practice Certificate of Registration and,
5. The applicant satisfies the non-exemptible requirements set out in Section 2(1) of Ontario Regulation 865/93.

*** Note**: The Policy may be extended to apply to other future scheduled sittings of the MCCQE2 as may be required during the pandemic.

****Note**: Applicants with prior exam failures may be directed to the Registrar for review by the Registration Committee under Section 2(1) of Ontario Regulation 865/93.

Appendix G

ALTERNATIVE TO THE MCCQE 2 EXAMINATION

If you are applying to practice medicine in Ontario, there is an option to undergo a practice assessment as an alternative to completing Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE).

You can apply for this practice assessment if you have:

i. Five or more years of independent practice experience;
ii. Certification by examination from the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada or are recognized as a specialist by the College of Physicians and Surgeons of Ontario;
iii. Successfully completed MCCQE Part 1, or an acceptable alternative;
iv. One year of successful practice in Ontario under supervision, demonstrated by the supervisor's reports to the CPSO.

Our Registration Committee considers each case individually. We will look at the nature and scope of your practice as well as your attempts at writing MCCQE Part 2. The Committee expects applicants to attempt the exam before applying for this practice assessment. Applicants must pay all costs associated with the assessment.

If you meet the criteria above, you may be permitted to undergo a practice assessment by the College. If we find your assessment report satisfactory, we will direct the Registrar to issue you a restricted certificate of registration. This will authorize independent practice, limited to your specialty or scope of practice.

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	June 16, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for June 16 and 17, 2022; and
- The minutes from the meeting of Council held March 3 and 4, 2022

Council Briefing Note

June 2022

Topic:	Executive Committee Report
Purpose:	For Information
Main Contact:	Lisa Brownstone, Chief Legal Officer
Attachment:	N/A

03-EX-Feb-2022 **Committee Appointment**

On a motion, moved by P. Pielsticker, seconded by I. Preyra, and carried that the Executive Committee approves the appointment of Dr. Xenodemetropoulos as the Vice-Chair of the Premises Inspection Committee (PIC) for a term expiring at the Annual General Meeting of Council in 2022.

01-EX-Apr-2022 (Joint GC/EC) **Committee Appointment**

On a motion moved by J. Fisk, seconded by I. Preyra and carried that the Executive Committee approves the appointment of Mr. Shahab Khan as a member of the Ontario Physicians and Surgeons Discipline Tribunal and Fitness to Practise Committee commencing on April 12, 2022 until the Annual General Meeting of Council in December 2024.

Contact: Janet van Vlymen, President
Lisa Brownstone, Chief Legal Officer

Date: June 2, 2022

Council Briefing Note

June 2022

Topic:	Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | Feb 15, 2022 – May 30, 2022
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	Accountability: Holding physicians accountable to their patients/clients, the public, and their regulatory body. Protection: Fulfilling the College's mandate to ensure public protection.
Main Contacts:	Dionne Woodward, Tribunal Counsel
Attachments:	None

Issue

- This report summarizes reasons for decision released between February 15, 2022 and May 30, 2022 by the Ontario Physicians and Surgeons Discipline Tribunal.
- It includes reasons on discipline hearings (liability and/or penalty), reinstatement applications, motions and case management issues brought before the Tribunal.
- This report is for information.

Current Status and Analysis

In the period reported, the Tribunal released 13 reasons for decision:

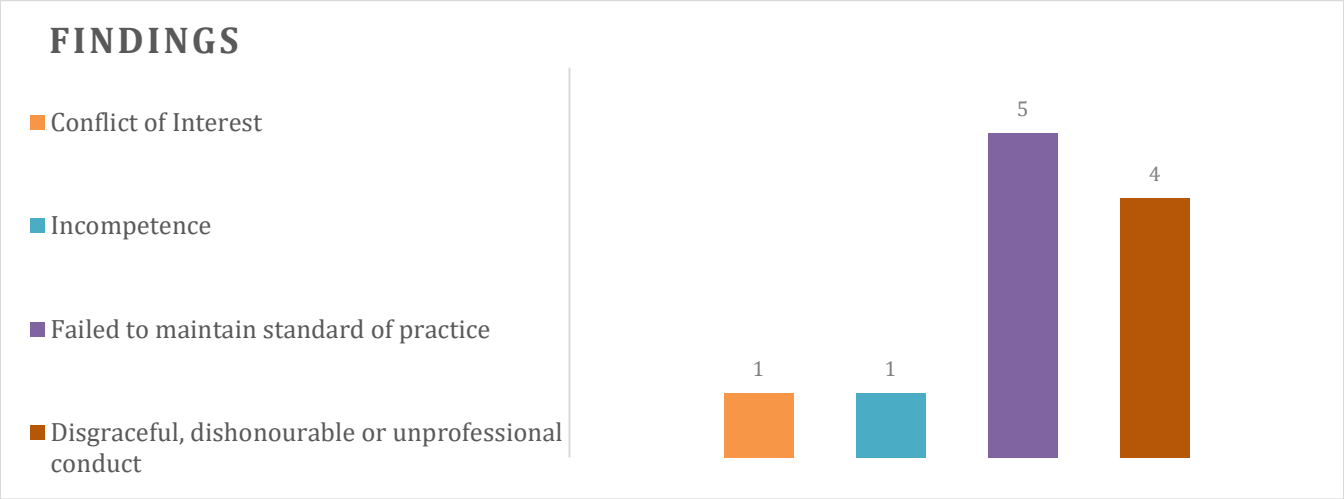
- 4 reasons on findings (liability) and penalty
- 2 reasons on findings only
- 1 set of reasons on penalty only
- 5 reasons on motions/case management
- 1 set of reasons on a reinstatement application

Findings

Liability findings included:

- 4 findings of disgraceful, dishonourable or unprofessional conduct
- 5 findings of failing to maintain the standard of practice
- 1 finding of incompetence
- 1 finding of having a conflict of interest

Figure 1: Types of Findings Issued During Reporting Period
**Note: Some cases had more than one finding*



Penalty

Penalty orders included:

- 5 reprimands
- 2 suspensions
- 2 revocations
- 1 imposition of terms, conditions or limitations on the physician's Certificate of Registration

Costs

The Tribunal imposed a costs order on the physician in all penalty reasons. The maximum costs ordered were $124,440 and the minimum costs ordered were $6,000.

Motions and case management decisions

For the period reported, the Tribunal released three orders and reasons for decisions on motions and two case management decisions.

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (February 15, 2022 to May 30, 2022)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Disgraceful, Dishonourable, Unprofessional	Failed to maintain standard of practice	Incompetence	Professional misconduct in another jurisdiction	Other
2022 ONPSDT 8	Pardis	Feb. 17, 2022	X	X	X		Conflict of Interest
2022 ONPSDT 9	Hanmiah	Feb. 24, 2022	X	X			
2022 ONPSDT 10	Morin	Mar. 14, 2022		X			
2022 ONPSDT 11	Fagbemigun	Mar. 21, 2022	X	X			
2022 ONPSDT 15	Bahrgard Nikoo	Apr. 25, 2022	X	X			
2022 ONPSDT 16	Cheng	May 3, 2022					No findings made; allegations not proven.
2022 ONPSDT 20	Margaliot	May 17, 2022					Reinstatement Hearing: The Tribunal reinstated the applicant's Certificate of Registration subject to terms and conditions.

TABLE 2: TRIBUNAL DECISIONS - PENALTIES (February 15, 2022 to May 30, 2022)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Term, Condition or Limitation)	Length of suspension in months	Costs
2022 ONPSDT 8	Pardis	Feb. 17, 2022	Reprimand; revocation		$10,370
2022 ONPSDT 9	Hanmiah	Feb. 24, 2022	Reprimand		$6,000
2022 ONPSDT 10	Morin	Mar. 14, 2022	Reprimand, suspension, TCL	1 month	$6,000
2022 ONPSDT 15	Bahrgard Nikoo	Apr. 25, 2022	Reprimand; suspension	12 months	$6,000
2022 ONPSDT 19	Ali	May 16, 2022	Reprimand; revocation		$124,440

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (February 15, 2022 to May 30, 2022)

Citation and hyperlink to published reasons	Physician	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2022 ONPSDT 12	Tzemos	Mar. 28, 2022	Motion for costs dismissed	The College withdrew the allegations against the member. Subsequently, the member sought legal costs on grounds that the commencement of proceedings was unwarranted. The panel dismissed the member's motion for costs.
2022 ONPSDT 13	McInnis	Apr. 7, 2022	Motion for adjournment granted	Medical information confirmed a serious deterioration in the member's mental health. Motion for adjournment granted to provide member an opportunity to be assessed by psychiatrist.
2022 ONPSDT 14	Aboujamra	Apr. 21, 2022	Motion dismissed – evidence found inadmissible	Expert evidence of forensic psychiatrist found inadmissible as its costs outweighed its benefits.
2022 ONPSDT 17	Kadri	May 10, 2022	Case Management-Scheduling request denied	Request to schedule hearing on a later date denied.
2022 ONPSDT 18	Kadri	May 11, 2022	Case Management-Clarification on Tribunal's jurisdiction provided	Clarified that the Tribunal does not have legal authority to decide matters outside of its jurisdiction (i.e. regarding the ethics and legalities of a model of care).

Council Briefing Note

June 2022

Topic:	Government Relations Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Government relations supports CPSO to regulate in a more effective, efficient, and coordinated manner.
Main Contact(s):	Miriam Barna, Senior Government Relations Program Lead Danna Aranda, Government Relations Coordinator
Attachment(s):	Appendix A: Submission on Proposed Regulations to Reduce Registration Barriers for Health Professionals Appendix B: Public Member Appointments Chart

Ontario Political Update

- The recent provincial election saw a landslide majority victory for the PCs, who won 83 out of the 124 seats.
    - The NDP will be returning to Queen's Park as the Official Opposition with 31 seats, which is down 9 seats from the 2018 election.
    - The Liberals are returning with one additional seat, for a total of 8, but remain below the 12 seat threshold needed for official party status.
    - Ontario Green Party leader Mike Schreiner remains the only Green Party representative at the legislature, after holding onto his riding in Guelph.

- Both the NDP and Liberal leaders stepped down on election night following disappointing results, and the details of these leadership races will be announced over the coming weeks.

- While it was known that several MPPs including Christine Elliott, Rod Phillips, Kathleen Wynne, among others, were not going to be seeking re-election, there were a number of notable surprises and wins on election night, including:
    - George Pirie (PC) defeated Gilles Bisson (NDP) in the riding of Timmins. Bisson served the riding for 32 years.
    - Michael Ford (PC), former Toronto City Councillor and nephew of the Premier, was elected in the riding of previously NDP held York South-Weston.
    - Charmaine Williams, Hardeep Grewal, and Graham McGregor, all PC candidates, were successful in dethroning NDP incumbents in the ridings of Brampton Centre, Brampton East, and Brampton North, respectively.
    - Dawn Gallagher Murphy (PC), who worked under former health minister Elliott, has won Elliott's previous riding of Newmarket-Aurora.

- Premier Ford has signaled that he will likely introduce "tweaks" to the previously introduced Budget. However, the government has interim spending authority until the fall, allowing for a delayed return to the legislature.

- While rumours are swirling about possibilities for a new Minister of Health, at this time, there is no clear indication of who this may be. Although no timeline has been given, it is likely that the legislature will briefly reconvene this summer to appoint a new Cabinet.

- Currently, the Legislature is scheduled to reconvene on September 12, 2022.

Issues of Interest

a) Registration Regulations Consultation

- In mid-April, Government passed Bill 106, the Pandemic and Emergency Preparedness Act, an omnibus bill that, among other things, amends the *Regulated Health Professions Act* with a goal to expand the province's workforce by "reducing barriers to registering with and being recognized by health regulatory colleges."

- Recently, the Ministry of Health consulted on proposed regulations (the specific text of the regulations has not been shared), that would support the implementation of the changes put forward in Bill 106 in regards to Canadian experience, language proficiency testing, timelines for registration decisions, and an emergency class of certificate.

- A brief summary of the consultation and our response is provided below, with the full submission attached in **Appendix A**.

- On removing Canadian experience requirements, the submission indicates our support for removing these barriers in general and identifies the action we regularly take to waive this requirement. It does note our willingness to develop discretion within this framework and how alternative pathways can be leveraged.

- Regarding standardizing language proficiency requirements, the submission expresses concern if standardization would require CPSO to assess and collect specific testing information as we currently assess language proficiency through alternate means.

- The regulatory registry posting proposes new timelines for registration, with set times for different elements of the registration process. The submission confirms our commitment to timely processing, while underscoring the need for clarification regarding when a timeline would start and the logistical challenges posed by some of the proposed timelines. An alternate proposal is put forward.

- Finally, on the requirement that all colleges have an emergency class of certificate, we indicate our support and point to CPSO's short-duration certificate as fulfilling the government's objectives.

b) Public Member Update

- Shahab Khan of Oakville was appointed to CPSO's Council for a 2-year term, ending March 3, 2024. Mr. Khan has subsequently been appointed to the Tribunal and Fitness to Practice Committee.

- In late March, Pierre Giroux submitted his letter of resignation as a public member of Council. While he will no longer participate in the work of Council and committees, he is still considered an official member of CPSO's Council until the Lieutenant Governor signs his appointment revocation Order in Council (OIC), likely to occur sometime this summer. As such, CPSO continues to have a complement of 15 public members (**See Appendix B**).

- As conversations with political staff resume over the coming weeks (with the appointment of a new Cabinet and the end of the caretaker period), staff will resume advocacy for the appointment of a 15th public member.

Interactions with Government

- Over the spring, and prior to the election being called, staff engaged with Ministry of Health officials on the implementation of physician assistant regulation, Bill 106 regulations, and public member issues.

- With the election behind us, there is an opportunity to re-establish existing relationship and build new ones with incoming MPPs and their staff.

CPSO

Trusted Doctors
Providing Great Care

June 10, 2022

Ministry of Health
Health Workforce Regulatory Oversight Branch
438 University Ave, 10th Floor
Toronto, ON
M7A 1N3

Re: Regulations under the *Regulated Health Professions Act*, 1991 – Registration Barriers for Regulated Health Professionals

The College of Physicians and Surgeons of Ontario (CPSO) appreciates the opportunity to comment on the Ministry of Health's proposed regulations to reduce registration barriers for health professionals under the *Regulated Health Professions Act, 1991*. Although time did not allow for CPSO to formally comment on *Bill 106, Pandemic and Emergency Preparedness Act, 2022*, CPSO is supportive of the bill's intent to improve access for foreign-credentialled healthcare workers to register with Ontario's health colleges.

In recent months, CPSO has responded to government consultations relating to governance modernization and reducing barriers to registration and, as always, welcomes the opportunity to share feedback on the current proposal. CPSO is a leader in reducing barriers to registration and supports the objectives set out in this regulatory proposal. The comments that follow outline areas of support, concern, and operational considerations, offered in hopes of strengthening the government's proposal and furthering the objectives of Bill 106.

1. Canadian Experience

Notwithstanding the Canadian experience criteria in CPSO's Registration Regulation, internationally trained applicants to CPSO are currently exempted via policy, where all other conditions of registration are met. CPSO remains strongly supportive of the government's intent to reduce barriers caused by Canadian experience requirements. As the development of this regulation is contemplated, it would be valuable to consider the potential unintended consequences of a wholesale invalidation of Canadian experience requirements. CPSO would be pleased to work with government to help develop a framework that preserves discretion in limited circumstances.

Additionally, alternative pathways can play an important role in minimizing the barrier of Canadian experience requirements while enhancing the clinical experience of internationally trained healthcare workers. This could be done by better leveraging and continuing to support Canadian experience opportunities prior to granting licenses to practice independently, through a Practice Ready Assessment program.

2. Language Proficiency

CPSO does not currently require language proficiency testing in order to register applicants. Instead, we assess language proficiency through the successful completion of other steps toward registration, such as certification examinations or as part of the residency match process. As noted in our response to the government's February 2022 consultation, CPSO is supportive of the intent of the proposal: that healthcare workers possess the appropriate language proficiency to practice in Ontario. However, these measures should not act as unnecessary barriers to registration or introduce a standardized testing requirement across all Colleges, solely for the sake of standardization.

As framed, the regulatory proposal is unclear whether standardization will require Colleges without a current testing requirement to introduce one. We are opposed to that outcome as it would create regulatory barriers for CPSO applicants, where none currently exist, and this would be contrary to the goal of Bill 106 and the philosophy of right-touch regulation.

In order to mitigate these unintended consequences, CPSO urges government to restrict new language proficiency testing to the Colleges that currently impose these requirements on applicants.

Should government choose to pursue a requirement for standardized testing, any testing requirement should be appropriate and suitable for the healthcare context, and not introduce irrelevant language requirements.

3. Time Limits

CPSO is committed to the timely processing of registration applications and consistently meet our transparent internal benchmarks, routinely processing applications within a 30-day timeline, and offering a fast track option for applications that do not require Registration Committee Review.

Government is proposing a 30-business day timeline for initial registration decisions of the Registrar under s.15(1) of the Health Professions Procedural Code (the Code). While CPSO is supportive of this 30-day timeline, it is imperative that the clock starts running after the Registrar is provided with a complete submission and any required supporting documentation is source-verified. Government must ensure that this is clearly indicated in the regulation.

In the second proposal, government appears to be proposing a 10-business day timeline for a subsequent decision of the Registration Committee under s.18 of the Code. This proposal lacks clarity as to when that timeline will begin and how it would align with the reality of CPSO's Registration Committee.

A 10-day timeline for scheduling and holding (and possibly writing its reasons for decision) a meeting of the Registration Committee is not workable. CPSO's Registration Committee is an extremely high-volume committee, with many cases reviewed by the panel at each meeting. Panels are scheduled every two weeks, usually far in advance. Panel members are typically given 10 days to review materials before a meeting: given the number of cases to be reviewed by the panel at each meeting and the complexity of issues considered by the Committee, this time is essential. In the event that the panel refuses an applicant, the panel needs time to write its reasons for decision, to which applicants are entitled, and this work takes up to 7 additional business days.

Additionally, and as noted above, the regulation must indicate that any timeline only be triggered once a complete and verified application is received.

Given these factors, CPSO recommends that government consider a minimum timeline of 30 business days for applications considered by the Registration Committee under s.18 of the Code, following the receipt of an applicant's complete submission with all supporting documents. These changes would allow government to achieve its objectives of consistent and prompt decision-making while recognizing the operational considerations of the Registration Committee.

CPSO appreciates the government's interest in setting timelines for applicants who are not domestic labour mobility applicants. However, given the heterogeneity of this group, the complexity of applications, and challenges relating to supporting documentation, we would suggest that government consider the development of benchmarks rather than the imposition of strict timelines. Government may want to consider the inclusion of a timelines benchmark for these applicants under the College Performance Measurement Framework.

4. Emergency Class

CPSO recognizes the value of expedited registration in emergencies and is broadly supportive of this proposal. Over the course of the COVID-19 pandemic, CPSO effectively leveraged an existing class (short-duration certificate) to facilitate this kind of registration.

It would appear that CPSO's current short-term duration certificate already effectively meets most of the proposed requirements set out in the regulatory proposal and we would welcome feedback from government as to whether this is the case or if modifications are required.

Of some concern however, we would assert that it is imperative that a path to transfer from <u>any</u> class to full licensure is only appropriate where the individual has been assessed against the requirements for independent licensure. More specifically, the regulatory proposal indicates an interest on the part of government to create a new pathway to independent licensure from the emergency class of registration. CPSO's position is that the requirements for independent practice must be satisfied in all cases in order to be granted this class of certificate.

CPSO

CPSO is eager to work with government to further its goals of reducing barriers to registration while we best fulfill our public interest mandate. We look forward to continued dialogue and collaboration as draft regulations are developed.

Sincerely,

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

Janet van Vlymen, MD
President

Appendix B - Public Member Appointments Chart

Public Member	Current Committee Appointment & Role	Date of First Appointment to Council	Date of Expiration of Current Appointment
Mr. Pierre Giroux		December 5, 2012	December 4, 2022
Dr. Lydia Miljan, PhD	ICRC (Specialty Panel Vice Chair, General); Governance	January 1, 2020	December 31, 2022
Mr. Shahid Chaudhry	ICRC; Registration	May 2, 2019	May 1, 2023
Ms. Joan Fisk	Executive; ICRC (Specialty Panel Chair, General)	November 1, 2017	November 19, 2023
Mr. Paul Malette	OPSDT; FTP; Quality Assurance; Registration	January 8, 2018	January 7, 2024
Mr. Jose Cordeiro	OPSDT; FTP	January 31, 2020	January 30, 2024
Ms. Linda Robbins	OPSDT; FTP	February 14, 2020	February 13, 2024
Mr. Shahab Khan	OPSDT & FTP	March 4, 2022	March 3, 2024
Mr. Peter Pielsticker	OPSDT; FTP; Executive; Finance; Quality Assurance	March 18, 2015	March 30, 2024
Mr. Murthy Ghandikota	ICRC; Registration; Finance	April 9, 2020	April 8, 2024
Ms. Shannon Weber	OPSDT; FTP; Governance	August 13, 2020	August 12, 2024
Ms. Julia Goyal	OPSDT; FTP	September 16, 2021	September 15, 2024
Mr. Rob Payne	OPSDT; FTP; Finance	October 29, 2020	October 28, 2024
Ms. Lucy Becker	OPSDT; FTP	August 12, 2021	December 31, 2024
Mr. Fred Sherman	ICRC	January 28, 2021	January 27, 2025

Council Briefing Note

June 2022

Topic:	Finance and Audit Committee Report
Purpose:	For Information
Main Contact(s):	Dr. Thomas Bertoia, Chair Finance and Audit Committee Nathalie Novak, Chief Operating Officer Douglas Anderson, Corporate Services Officer Leslee Frampton, Manager Finance
Attachment(s):	N/A

Issue

- The Finance and Audit Committee met on April 7, 2022 and has the following summary for the June 2022 Council meeting

Finance and Audit Committee Summary

The Finance and Audit Committee addressed the following agenda items:

- The Committee discussed the 2022 work plan
- The Committee reviewed the year end 2021 Financial Statements and Variance Analysis
- Tinkham LLP Chartered Professional Accountants presented the 2021 Audited Financial Statements to the Committee
- The Committee held an in-camera meeting with the auditors
- The Committee discussed the budget objectives for 2023
- The Committee reviewed the updated Finance and Audit Committee Terms of Reference
- The Committee deliberated on the Council and Committee per diem updates
- Lori Webel-Edgar from HIROC gave the Committee a detailed update on FIRMS

Council Briefing Note

June 2022

Topic:	Policy Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Keeping Council apprised of ongoing policy-related issues and activities for monitoring and transparency purposes.
Main Contact(s):	Craig Roxborough, Director, Policy
Attachment(s):	Appendix A: Policy Status Report

Issue

- An update on recent policy-related activities is provided to Council for information.

Current Status

1. Policy Consultation Update

Physicians' Relationships with Industry: Practice, Education and Research

- The preliminary consultation took place from December 2021 to March 2022. Recognizing the impact of the pandemic on the profession and key stakeholders' ability to participate, the deadline for providing feedback was extended beyond the typical 60 days.

- The consultation received 94 responses: 14 through written feedback and 80 via the online survey. A majority of the respondents were physicians, and feedback was also received from four organizational respondents.[1]

[1] The Ontario Medical Association (OMA), the Professional Association of Residents of Ontario (PARO), and the Information and Privacy Commissioner of Ontario (IPC) responded with written feedback; the Canadian Association of Radiologists provided a survey response.

- A partial overview of the feedback received from these engagement activities was provided in the March 2022 Policy Report to Council. Most of the feedback received following the March 2022 Council submission deadline was similar in focus to what was already reported, but also included constructive feedback regarding:
    - Referral and ordering practices and operating a practice;
    - Different types and examples of conflicts;
    - Alternatives to "meals of modest value" and "fair market value;" and
    - Rules around drug samples.
- All of the written feedback received can be viewed on the consultation webpage.
- A draft revised policy is now being prepared based on the consultation feedback, feedback from the Policy Working Group meeting held in May, and research undertaken in accordance with the usual policy review process.

Out of Hospital Premises (OHP) Standard: Image Guidance When Administering Nerve Blocks for Adult Chronic Pain

- The preliminary consultation took place from December 2021 to March 2022. Recognizing the impact of the pandemic on the profession and key stakeholders' ability to participate, the deadline for providing feedback was extended beyond the typical 60 days.
- The consultation received 6,050 responses: 5,697 through written feedback and 353 via the online survey. The majority of the responses received were members of the public as part of an organized letter-writing campaign[2], and feedback was also received from 14 organizational respondents.[3]
- A partial overview of the feedback received from these engagement activities was provided in the March 2022 Policy Report to Council. Most of the feedback received following the March 2022 Council submission deadline was similar in tone to what was already reported.
- The feedback received was polarized, with many respondents indicating that the draft *OHP Standard* would improve the quality, safety, and efficacy of interventional pain management

[2] Organizational respondents included: Canadian Academy of Pain Management; Chronic Pain Association of Canada; College of Physicians and Surgeons of Alberta (CPSA); Directors, Pain Medicine Residency Programs (University of Ottawa; McMaster University; University of Toronto; Western University); Ontario Association of Pain Management; Ontario Headache Consortium; OMA Pain Section; OMA Section on Addiction; Pain Medicine, Kingston Health Sciences Centre and Queen's University; Pain Medicine Residency Program Committee, Department of Anesthesiology and Pain, University of Toronto; Patients of Eastern Ontario Pain Lifestyle Education (PEOPLE) Centre; PARO; and Toronto Academic Pain Medicine Institute (TAPMI).
[3] CPSO received 4,565 form letter responses from individual respondents containing similar content and sentiments. While each response was not posted on the online discussion board, these responses were read and considered as part of the public consultation.

while others felt that it would potentially reduce access to care for chronic pain patients and impose increased costs and administrative burdens on OHPs.

- All of the written feedback received can be viewed on the consultation webpage.

- Further engagement activities were undertaken as part of the consultation, including meeting with key stakeholders, such as the OMA Section on Chronic Pain and physicians practising in chronic pain.

2. Preliminary Consultations: *Blood Borne Viruses* and *Mandatory and Permissive Reporting*

- Preliminary consultations on CPSO's *Blood Borne Viruses* and *Mandatory and Permissive Reporting* policies will be launched following the June 2022 Council Meeting.

- The policy reviews will be conducted in accordance with CPSO's commitment to Right-Touch Regulation and continued modernization.

- All feedback received during the preliminary consultations will be analyzed and will help inform the policy reviews.

- Council will be provided with further detail about the results of these preliminary consultations at future meetings.

3. 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.

Appendix A: Policy Status Report – June 2022 Council

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Blood Borne Viruses	Jun-22	✓						**2024**	
Mandatory and Permissive Reporting	Jun-22	✓						**2024**	
Physicians' Relationships with Industry: Practice, Education and Research	Dec-21		✓					**2023**	
Dispensing Drugs	Sep-21			✓				**2022**	
Professional Obligations and Human Rights	Dec-20		✓					**2023**	
Medical Assistance in Dying	Dec-20		✓					**2023**	
Planning for and Providing Quality End-of-Life Care	Dec-20			✓				**2023**	The draft policy has been retitled to *Decision-Making for End-of-Life Care*.
Telemedicine	Sep-20						✓	**2022**	The revised draft policy for final approval has been retitled to *Virtual Care*.
Social Media: Appropriate Use by Physicians **(Statement)**	Apr-20						✓	**2021**	The revised draft policy for final approval has been retitled to *Social Media*.
Statements & Positions Redesign	Jan-20		✓					**2022**	All CPSO *Statements & Positions* are being evaluated for relevance and currency.

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Providing Physician Services During Job Actions	2018/19	*Transitions in Care*	2024/25
Cannabis for Medical Purposes	2020/21	*Walk-in Clinics*	2024/25
Consent to Treatment	2020/21	*Disclosure of Harm*	2024/25
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	*Prescribing Drugs*	2024/25
Physician Behaviour in the Professional Environment	2021/22	*Boundary Violations*	2024/25
Accepting New Patients	2022/23	*Medical Records Documentation*	2025/26
Ending the Physician-Patient Relationship	2022/23	*Medical Records Management*	2025/26
Uninsured Services: Billing and Block Fees	2022/23	*Confidentiality of Personal Health Information*	2025/26
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24	*Advertising*	2025/26
Public Health Emergencies	2023/24	*Delegation of Controlled Acts*	2025/26
Closing a Medical Practice	2024/25	*Professional Responsibilities in Medical Education*	2025/26
Availability and Coverage	2024/25	*Third Party Medical Reports*	2025/26
Managing Tests	2024/25	*Complementary and Alternative Medicine*	2026

Ontario Medical Students' Association
CPSO Council Update
June 16-17, 2022

Presented by:
Angie Salomon, President
Jeeventh Kaur, President-Elect

OMSA Ontario Medical Students Association
AÉMO Association des étudiant·e·s de médecine de l'Ontario

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting.

OMSA represents the interests and concerns of Ontario's 4000+ medical students, and is entrusted with advocating for changes in education, health policy, and care delivery that will benefit the future physicians of Canada and the communities that we serve.

Since the last CPSO meeting, OMSA has successfully implemented a number of significant initiatives and events. We hosted the i**naugural OMSA Equity, Diversity, Inclusion, and Decolonization conference titled "Reimagining Medical Education"** that brought together students, faculty, and advocates from various schools and communities in Ontario to to identify EDID gaps in the curriculum, showcase grassroots efforts for curriculum reform, and discuss systemic solutions. We also carried out our provincial **Day of Action focusing on Long Term Care reform**, with asks to phase out for-profit care models, increase wages and improve working conditions for LTC staff, and mandate a minimum 4 hours of direct care per patient per day. We also hosted a **wellness retreat**, bringing together over 40 students from across the province to **connect with nature and one another** in their lifelong pursuit of sustainable wellness.

This past month, OMSA hosted its first **in-person Leadership Summit and Annual General Meeting (AGM)** since 2019! Through speakers and workshops, we helped over 60 Ontario medical students **explore innovative, unorthodox, and "out-of-the-box" leadership styles.** At the AGM, we elected our 2022-2023 OMSA Executive Board. **Angie Salomon** has transitioned into her role as OMSA President & Chair of OMA Section of Medical Students, and **Jeeventh Kaur** was elected President-Elect. The new Board brings a fresh wave of energy and ideas and they look forward to collaborating with CPSO in the months to come.

Thank you for welcoming medical students to the table and we look forward to continuing to work together.

Sincerely,

Angie Salomon
President, OMSA
president@omsa.ca

Jeeventh Kaur
President-Elect, OMSA
president_elect@omsa.ca

PARO

Inspired by our love of medicine

CPSO Council May 2022

PARO champions the issues that create the conditions for residents to be their best and ensure optimal patient care. We have determined that to fulfill this mission we must achieve three key goals.

Optimal training - so that residents feel confident to succeed and competent to achieve excellence in patient care.

Optimal working conditions - where residents enjoy working and learning in a safe, respectful, and healthy environment.

Optimal transitions – into residency, through residency, and into practice – so that residents are able to make informed career choices, have equitable access to practice opportunities, and acquire practice management skills for residency and beyond.

We are pleased to submit this update on some organizational projects, info related to COVID-19 as well as some strategic initiatives at PARO.

Burnout and Morale Mitigation

We continue to have members experiencing high levels of burnout due to the ongoing pressures of the pandemic. We continue the initiatives we began to mitigate the isolation and low-morale our members are experiencing. In addition to initiatives targeting our members directly, PARO has been arranging for burnout mitigation sessions for the Program Administrators in all programs in partnership with PGME across the province. In addition to a presentation from an external provider on how PAs could recognize and manage burnout, we include a segment on supporting residents to mitigate their burnout. We are very pleased at this opportunity to partner with the University sites to deliver that programming.

Transitions To, During and From Leave

PARO is exploring how we might assist residents who are transitioning back into residency after a leave whether it is those who take time away from clinical service to engage in research (CIP or other types), personal academic leave (to do a Masters or PHd) or maternity/parental leave and medical leave among others.

To enable us to do this work, PARO obtained in our most recent Collective Agreement the provision of information from our PGMEs/paymasters on any member who goes on a leave in excess of 30 days. This will enable us to provide relevant and helpful information to assist them through their leaves. This will be in addition to some of the other work we have been doing, such as through our social media postings on our Instagram account and be more targeted to their personal circumstances

Government MRRP (Medical Resident Redeployment Program)

After significant work by PARO, we are very pleased that the Government has continued to extend the MRRP as COVID continues to impact health human resources and patient needs in our hospitals. This program enables residents to provide much-needed additional service resulting from the impact of COVID, and to receive payment at a rate of $50 per hour. Our priority was to ensure that all residents could be eligible to participate in providing service on a voluntary basis, and to ensure that they would receive extra pay for doing so as a tangible way of recognizing their contribution. The Program has now been extended three times - most recently through to September 30, 2022.

As we found the MRRP was being under-utilized we have been working hard to encourage use of the Program at our hospitals with support from PGME, and we are pleased that the sites have increased utilization of the program. At this juncture, our PG Deans have identified that it has been a critical factor in meeting the resource challenges. It has also enabled sites to decrease use of university rotation-redeployment. Therefore, whether residents have personally participated in the program, it has improved morale broadly amongst members.

If you want more details on the Program, which save for the extension is unchanged, PARO's FAQ remains on the PARO COVID Webpage.

PARO Awards

This year, PARO celebrated the recipients of the 2022 PARO Awards over the course of 7 virtual events. Our Board team hosted resident, medical student, and clinical teacher recipients from each University Site (with two events for the University of Toronto) alongside their friends and family with participation and remarks by PARO and the Postgraduate Deans. The events celebrated the achievements of each recipient, highlighted quotes from their nomination letters, and offered them a chance to share remarks. Though we have missed our PARO Awards Banquet, as have our PG Deans, we have been very pleased at the sense of celebration we have been able to achieve in our virtual events, and the fact that it does allow for our Recipients to bring as many friends and family to the event as they would like.

Academic Days Best Practices

Residents from across specialties and training programs value Academic Days and the contribution they make to residency education. Over the years, residents have identified that there is a great deal of variation in how this time is structured and how teaching is delivered.

In order to support programs looking to optimize their Academic Days, we asked our members to share what they love about their Academic Days, and the approaches that help them learn best. Based on the feedback from hundreds of residents from across the province, PARO has articulated a vision of success for Academic Days and curated a selection of best practices for programs to consider implementing.

The final Best Practice guide will be available in late Spring/early Summer of 2022.

Integration of Virtual Care in Medical Education

Virtual care encompasses all the ways that healthcare providers remotely interact with their patients. We previously updated that the PARO Board directed a team to determine how an optimal virtual care curriculum might be developed and integrated into medical education in a way that creates the conditions for resident training to be enhanced. Although PARO is not in a position to directly impact curriculum development and implementation, we can play a valuable role by sharing the resident perspective and highlighting the opportunities to streamline and leverage current training presented by virtual care. We can also empower residents to understand existing best practices, such as to respect privacy standards and to promote resident safety.

Last year, we brought together a group of residents comprised of PARO General Council representatives and general members for a facilitated session to clarify the issues related to virtual care and discuss how PARO might best support members. In June 2021 the PARO Board approved the Team's strategic framework for this initiative and their plan for next steps. Further work was done with the PARO General Council to learn more about the Ontario resident experience with virtual care. Based on the input, we developed a Best Practices/FAQ guide for residents and a PARO perspective paper on care standards and training implications for virtual care.

This work has now been completed, and we have shared the Best Practices/FAQ Guide for Residents and our PARO Perspective Paper to our 6 PG Deans, various stakeholder organizations including the CPSO, and our PARO Members with encouragement to share with Program Directors and Program Admins. As Virtual Care in Medical Education will continue to evolve, and our learning from it, we will update our documents accordingly.

PARO Board of Directors
June 3rd I will move into the position of PARO President. Dr. Carl White Ulysse transitions into the role of Past President and Dr. Ari Cuperfain, our current Treasurer, was elected to a second term. The rest of the PARO Board is elected at our June GC meeting (June 3rd).

I look forward to continuing our work with the CPSO and other stakeholders to create optimal conditions for residency so that we can best serve the interests of the patients and peoples of Ontario.

Kind Regards,

Brendan Lew, MD, MPH, CCFP
President-Elect, PARO Board of Directors

Council Briefing Note

June 2022

Topic:	Update on Council Decisions
Purpose:	For Information
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration, Continuous Improvement
Public Interest Rationale:	Accountability: Holding Council and the College accountable for the decisions made during the Council meetings
Main Contacts:	Lisa Brownstone, Chief Legal Officer Cameo Allan, Manager of Governance Adrianna Bogris, Council Administrator

Issue

- To promote accountability and ensure that Council is informed about the status of the decisions it makes, an update on the implementation of Council decisions is provided below.

Current Status

- Council held a meeting on March 3 and 4, 2022. The motions carried and the implementation status of those decisions are outlined in Table 1.

Table 1: Council Decisions from March Meeting

Reference	Motions Carried	Status
01-C-03-2022	**Consent Agenda** The Council approves the items outlined in the consent agenda, which include in their entirety: • The Council meeting agenda for March 3 & 4, 2022, as amended; and • The minutes from Council held December 9 & 10, 2021	Completed.

Reference	Motions Carried	Status
N/A	Items for information: 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Policy Report 3.5 Medical Learners Report 3.6 Update on Council Action Items	N/A
02-C-03-2022	**Governance Committee Report – Committee Appointment** The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Madhu Azad to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practice Committee, effective immediately, for a term ending at the Annual General Meeting of Council 2024.	Completed.
03-C-03-2022	**Proposed By-law Amendments regarding Tribunal References** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 147: **By-law No. 147** 1. Paragraph (a) of subsection 22(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”. 2. Paragraph (a) of subsection 27(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”. 3. Paragraph (a) of subsection 36(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”. 4. Section 40b of the General By-law is amended by adding the following at the end of the section:	Completed.

Reference	Motions Carried	Status
	For ease of reference, the Ontario Physicians and Surgeons Discipline Tribunal is referred to in this General By-law by its English name or acronym, and all references to the English name or acronym shall be deemed to equally refer to or apply to its French name or acronym, respectively.	
04-C-03-2022	**By-law Amendments for Reduced Membership Fees for Parental Leaves** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 143: **By-law No. 143** (1) Section 4 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following: **4.** Annual fees, as of June 1, 2018, are as follows: (a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration; (b) For a holder of a certificate of registration authorizing postgraduate education applying to renew his/her certificate of registration, 20% of the annual fee set out in subsection 4(a); and (c) Notwithstanding subsections 4(a) and (b), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is as follows: i. 50% of the annual fee set out in subsection 4(a) for holders of a certificate of registration (except as set out in	Completed.

Reference	Motions Carried	Status
	subsection 4(c)(ii)); or ii. 50% of the annual fee set out in subsection 4(b) for holders of a certificate of registration authorizing postgraduate education, so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. Where applications for the parental leave reduced annual fee are received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This subsection 4(c) only applies to annual fees for membership years commencing on or after June 1, 2020. (2) Section 4.1 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following: **4.1** Annual fees for a holder of a certificate of authorization, as of January 1, 2017, are $175.	
05-C-03-2022	**Proposed Register By-law Amendments** The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 148, after circulation to stakeholders: **By-law No. 148** (1) Paragraphs 12, 13, 14, 17 and 17.1 of subsection 49(1) of the General By-law are revoked and substituted with the following: 12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations and relinquishments of the	Consultation complete. Amendments to June Council for final approval.

Reference	Motions Carried	Status
	member's privileges or practice, and rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the Public Hospitals Act, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect. 13. If an allegation of professional misconduct or incompetence against the member has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided, i. a summary of the allegation if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to September 10, 2013, ii. a summary of the allegation and/or the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal after September 10, 2013, iii. an indication that the matter has been referred to the Ontario Physicians and Surgeons Discipline Tribunal, iv. the anticipated date of the hearing, if the date has been set, v. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of the adjournment, and vi. if the decision is under reserve, that fact. 14. If the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register, i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding,	

Reference	Motions Carried	Status
	ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty, and iii. if the finding is appealed, the status of the appeal and the disposition of the appeal. 17. If an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal, i. that fact, ii. the dates on which the application is scheduled to be heard, iii. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of that adjournment, and iv. if the decision is under reserve, that fact. 17.1 If an application to the Ontario Physicians and Surgeons Discipline Tribunal for reinstatement has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal. (2) The following are added as paragraphs 17.3 and 17.4 of subsection 49(1) of the General By-law: 17.3 If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed, i. that fact, ii. the dates on which the application is scheduled to be heard, iii. if the hearing has been adjourned and no future date has been set, the fact of that adjournment, and iv. if the decision is under reserve, that fact. 17.4 If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been	

Reference	Motions Carried	Status
	decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.	
06-C-03-2022	**Medical Psychotherapy Association of Canada Third Pathway** The Council of the College of Physicians and Surgeons of Ontario extends the status of the Medical Psychotherapy Association of Canada as a third pathway of Continuing Professional Development (CPD) until September 2024.	Completed.
07-C-03-2022	**Rescinding and Revising Registration Policies – Post MCCQE2 Changes** 1. The Council of the College of Physicians and Surgeons of Ontario approves the following: (a) The revised policy "Restricted Certificate of Registration for Exam Eligible Candidates", (a copy of which forms Appendix "A" to the minutes of this meeting); (b) The revised policy "Recognition of Certification Without Examination Issued by the CFPC" (a copy of which forms Appendix "B" to the minutes of this meeting); (c) The revised Directive, Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for "Residents Working Additional Hours for Pay" (a copy of which forms Appendix "C" to the minutes of this meeting); (d) The revised Directive, Approval of the Imposition of Terms, Conditions and Limitations Proposed by the Registrar for "Camp Doctors" (a copy of which forms Appendix "D" to the minutes of this meeting); and (e) The Specific Direction to the Registrar from the Registration Committee – Licentiate of the Medical	Completed.

Reference	Motions Carried	Status
	Council of Canada (LMCC) Policy (a copy of which forms Appendix “E” to the minutes of this meeting). 2. The Council of the College of Physicians and Surgeons of Ontario rescinds the following Registration Policies: (a) “Requirement for the Successful Completion of the MCCQE 2- Pandemic Exemption” (a copy of which forms Appendix “F“ to the minutes of this meeting); and (b) “Alternative to the MCCQE 2 Examination” (a copy of which forms Appendix “G” to the minutes of this meeting).	

Council Briefing Note

June 2022

Topic:	*Dispensing Drugs* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Setting out up-to-date and clear expectations and guidance for physicians who dispense drugs
Main Contact:	Alex Wong, Policy Analyst
Attachments:	Appendix A: Draft *Dispensing Drugs* policy Appendix B: Draft *Advice to the Profession: Dispensing Drugs*

Issue

- The College's *Dispensing Drugs* policy is currently under review. A new draft policy has been developed along with a new companion *Advice to the Profession* document.

- Council is asked whether the draft policy can be released for an abridged external consultation and engagement process.

Background

- The *Dispensing Drugs* policy previously underwent minor housekeeping amendments in November 2018 and was part of a batch of redesigned policies in September 2019. However, it has not undergone a formal policy review since it was first drafted and consulted on in 2008 and approved by Council in 2010.

- In light of recent housekeeping updates and given the niche nature of the policy, the policy was selected to undergo an accelerated policy review process, shortening the length of the preliminary consultation and foregoing review by the Policy Review Working Group.[1]

[1] Historically, not all policies were supported by a policy review working group. In particular, policies that were more straightforward, not subject to significant change since being last reviewed, or with only few professional expectations over and above legislative obligations were often not supported by a working group. Since the new standing Policy Review Working Group was constituted in 2019, this is the first policy review to come forward meeting the aforementioned criteria.

- Preliminary research was undertaken in accordance with the usual policy review process.[2] In addition, feedback on the current policy was solicited through a 30-day preliminary consultation that was held in fall 2021.

    - The preliminary consultation garnered a total of 19 responses: 3 through written feedback and 16 via the online survey. The majority of responses were from physicians.

    - Some of the constructive feedback received from respondents included:

        - Indicate any new relevant legislative requirements;

        - Expand on the practical steps required to dispense and provide more specific guidance around issues such as procurement, storage, and packaging; and

        - Create an *Advice to the Profession* document to provide further guidance and/or reference existing resources in the policy.

Current Status and Analysis

- A draft *Dispensing Drugs* policy (**Appendix A**) and companion *Advice to the Profession* document (**Appendix B**) have been developed, taking into consideration the research and preliminary consultation feedback noted above.

- The draft policy and *Advice to the Profession* companion document were developed in consultation with the Ontario College of Pharmacists. Additional support was provided by Keith Hay (Medical Advisor) and Jessica Amey (Legal Counsel).

Draft *Dispensing Drugs* Policy

- The draft policy expectations are largely consistent with those of the current policy and are based on the premise that physicians must meet the same dispensing standards as pharmacists. The intention of the policy is to set expectations for physicians acting in a role that is comparable to a pharmacist.

- Updates to the draft policy were made to enhance clarity of language, to ensure references to legislation were current (e.g., references to expired legislation removed), and to re-organize the policy's provisions.

- New policy expectations were also added to the draft policy related to:

    - providing patient counselling, including discussing instructions for proper drug use;

[2] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian medical regulatory authorities; information from the Inquiries, Complaints, and Reports Committee (ICRC); and feedback from the College's Physician Advisory Service (PAS).

  - being transparent and informing the patient of the option to purchase drugs from a pharmacy of their choice, if that option is available; and
  - monitoring recalled drugs and having a process for contacting patients whose drugs are affected.

- The policy expectations were added predominantly in response to the research conducted above. They mirror requirements found in some other jurisdictions and focus on ensuring patients are appropriately informed when physicians dispense drugs to them.

Draft *Advice to the Profession* document

- In response to stakeholder feedback, a new *Advice to the Profession* companion document was developed to provide additional guidance to assist physicians in meeting the expectations set out in the policy.

- The *Advice to the Profession* expands on the technical and cognitive components of dispensing and provides further information and links to resources around key expectations, including related to:
  - reasonable dispensing fees;
  - information to provide as part of patient counselling;
  - information to include on labels;
  - use of proper methods of procurement; and
  - appropriate and secure storage of drugs.

Next Steps

- Subject to Council's approval, the draft policy will be released for external consultation and engagement.

  - In keeping with an accelerated policy review process, a shortened consultation period of 45 days is planned.

- Feedback received as part of these activities will be shared with Council at a future meeting and used to further refine the draft.

Questions for Council

1. Does Council approve the draft *Dispensing Drugs* policy for external consultation and engagement?

Dispensing Drugs

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.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Dispensing: refers to the process of preparing and providing a prescription drug to a patient for subsequent administration or use.[1] Dispensing involves both technical and cognitive components.[2]

Policy

1. Physicians who dispense drugs **must** meet the same dispensing standards as pharmacists[3] and comply with the requirements set out in this policy, in any other relevant College policies,[4] and provincial and federal legislation.[5]

2. Physicians **must** dispense drugs only for their own patients.

3. Physicians **must:**

[1] The policy does not apply to the distribution of drug samples. Relevant expectations relating to drug samples can be found in other College policies, including *Medical Records Documentation*, *Prescribing Drugs*, and *Physicians Relationships' with Industry: Practice, Education and Research*. For more information, see the *Advice to the Profession.*

[2] Technical components may include drug selection, verification, and quantity determination, applying appropriate labelling, and documentation. Cognitive components may include assessing the appropriateness of drug therapy, considering drug interactions and contraindications, providing patient communication and counselling, and offering follow-up advice. For more information see the *Advice to the Profession.*

[3] For example, see the Ontario College of Pharmacists' (OCP) Standards of Practice.

[4] Including, but not limited to, the *Prescribing Drugs* policy and the *Medical Records Documentation* policy.

[5] Including, but not limited to, the *Controlled Drugs and Substances Act*, the *Narcotics Safety and Awareness Act, 2010*, the *Drug and Pharmacies Regulation Act* (*DPRA*), the *Drug Interchangeability and Dispensing Fee Act*, and the *Food and Drugs Act*. These acts and their regulations set out requirements for the sale and dispensing of drugs, including labelling, record keeping, and record retention.

a. provide appropriate packaging and labelling for the drugs dispensed;[6] and
b. provide patient counselling, including discussing instructions for proper drug use.

4. Physicians **must not** sell drugs to a patient at a profit, except when permitted by legislation.[7]

5. Physicians **must** be transparent and inform the patient of the option to purchase the drug(s) from a pharmacy of their choice, if this option is available.

6. Physicians **must not** charge a dispensing fee that is excessive.[8]

7. Physicians **must not** dispense drugs that are past their expiry date or that will expire before the patient completes their normal course of therapy.[9]

8. Physicians **must**:
   a. use proper methods of procurement in order to confirm the origin and chain of custody of drugs being dispensed;
   b. have an audit system in place in order to identify possible drug loss;
   c. store drugs securely;
   d. store drugs appropriately to prevent spoilage (for example, temperature control where necessary);
   e. monitor recalled drugs[10] and have a process for contacting patients whose dispensed drugs are affected; and
   f. dispose of drugs that are unfit to be dispensed (for example, expired or damaged) safely and securely and in accordance with any environmental requirements.[11]

9. Physicians **must** keep records:
   a. of the purchase and sale of drugs; and
   b. which allow for the retrieval and/or inspection of prescriptions.

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[6] Subsection 156(3) of the *DPRA* sets out the information to be recorded on the container of a dispensed drug. The *Food and Drug Regulations* sets out specific requirements for physicians dispensing Class A opioids. For more information, see the *Advice to the Profession*.
[7] It is not a conflict of interest to sell or otherwise supply a drug to a patient at a profit where the drug is necessary for the immediate treatment of the patient, in an emergency, or where the services of a pharmacist are not reasonably readily available (Section 16 (d), O. Reg. 114/94 under the *Medicine Act*).
[8] It is an act of professional misconduct to charge a fee that is excessive in relation to the services provided (Subsection 1(1) paragraph 21, O. Reg. 856/93 under the *Medicine Act*).
[9] This requirement does not apply to *pro re nata* (PRN) medications, when physicians may not know whether patients will finish the medication before their expiry date.
[10] For instance, through Health Canada's Recalls and Safety Alerts Database or subscribing to MedEffect Canada notices of recalls.
[11] For more information about the safe disposal of drugs, please see the College's *Advice to the Profession: Prescribing Drugs*.

Advice to the Profession: Dispensing Drugs

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 College, in consultation with the Ontario College of Pharmacists, has developed the *Dispensing Drugs* policy for those physicians who dispense drugs. The aim of the policy is to ensure that physicians and pharmacists meet the same standards when dispensing drugs. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the policy and provide guidance for how these obligations can be effectively discharged.

What is dispensing?

The Ontario College of Pharmacists' *Dispensing Components Included in the Usual and Customary Fee* guideline describes dispensing as involving both technical and cognitive components. Technical components of dispensing may include drug selection, verification, and quantity determination, applying appropriate labelling, and documentation. Cognitive components of dispensing, which may overlap with a physician's responsibilities when prescribing, may include assessing the appropriateness of drug therapy, considering drug interactions and contraindications, providing patient communication and counselling, and offering follow-up advice. Additional information on the components of dispensing can be found in the Ontario College of Pharmacists' guideline.

Does this policy apply if I am distributing drug samples?

The intention of the policy is to set expectations for physicians acting in a role that is comparable to a pharmacist and does not apply to the distribution of drug samples. However, relevant expectations for drug samples are found in the *Medical Records Documentation*, *Prescribing Drugs*, and *Physicians Relationships' with Industry: Practice, Education and Research* policies, such as documentation of the drug name, dose, directions for use, quantity, and lot number in the patient's medical record.

Some of the expectations articulated in the *Dispensing Drugs* policy are nevertheless informative and may help guide appropriate conduct when it comes to distributing drug samples. This includes not distributing expired medications and checking that samples are correctly labelled. Further guidance around distributing drug samples can be found in the Ontario College of Pharmacists' *Distribution of Medication Samples* policy.

How can I determine what dispensing fee to charge?

A reasonable dispensing fee may incorporate handling costs, such as shipping and secure storage for the drug. Further guidance on charging for uninsured services more generally can be found in the *Uninsured Services: Billing and Block Fees* policy.

What information do I need to provide to a patient when dispensing a drug?

Patient counselling is an important aspect of dispensing. Many aspects of patient counselling overlap with a physician's responsibility to obtain informed consent from a patient or their substitute decision-maker for treatment and before prescribing a drug. Judgment can be exercised as to what is discussed when dispensing repeats or refills of medication. Physicians can provide information to patients such as directions for using the drug, the expected therapeutic effect, potential side effects, drug contraindications and precautions, as well as information about the drug therapy as it relates to the patient's condition. Physicians can also communicate with patients in order to evaluate their ability to comply with the therapeutic regimen.

What information do I need to include on labels for dispensed drugs?

Subsection 156(3) of the *Drug and Pharmacies Regulation Act* sets out the information which must be recorded on the container of the dispensed drug. This includes, but is not limited to, the identification number on the prescription; drug name, strength, and manufacturer; the date the prescription is dispensed; the name of the prescriber; the name of the person for whom it is prescribed; and the directions for use as prescribed.

Under the *Food and Drug Regulations*, physicians who dispense Class A opioids are required to apply a warning sticker to the prescription bottle, container, or package, and provide a patient information handout to accompany the drug. A sticker or handout is not required if the drug is being administered under the supervision of a practitioner (for example, a physician or nurse practitioner). For more information about these requirements, see Health Canada's FAQ.

What do I need to know about procuring drugs?

The policy requires physicians to use proper methods of procurement in order to be assured of the origin and chain of custody of the drugs they dispense. This includes keeping documentation of each sale or product transaction, for example, with a packing slip from the manufacturer or wholesaler. Physicians can meet this expectation by procuring drugs from reliable sources and in accordance with federal legislation, such as from manufacturers or wholesalers who have been issued drug establishment licences by Health Canada.

For controlled substances, physicians must keep purchase/receiving records that contains information about the name and quantity of the substance received; the date the substance was received; and the name and address of the person from whom the substance was received.

Additional guidance can be found in the Ontario College of Pharmacists' policy on medication procurement and inventory management and fact sheet on federal purchase and sales record requirements, and Health Canada's *Recommended guidance in the areas of security, inventory, reconciliation and record-keeping for community pharmacists*.

What do I need to do to store drugs securely and appropriately?

Physicians will need to implement practices that enable storing drugs in a clean and organized area, with appropriate temperature, light, humidity, ventilation, regulation, security, and safety controls. It is important for drugs to be located in areas appropriate to their drug classification and that storage areas are accessed only by designated and appropriately trained personnel.

With respect to storing controlled substances, the regulations do not define what is considered reasonable or necessary to ensure security nor do they establish specific storage requirements. Physicians may choose to implement a combination of methods, such as physical security measures (e.g., alarm system, locks, video surveillance, restricted access), inventory management (e.g., physical counts, accurate record-keeping), operational processes, audits, and inventory reconciliation.

Additional guidance and resources can be found in the Ontario College of Pharmacists' policy on medication procurement and inventory management and fact sheet on security and reconciliation of controlled substances, and Health Canada's *Recommended guidance in the areas of security, inventory, reconciliation and record-keeping for community pharmacists*.

How can I minimize dispensing errors?

Medication incidents or medication errors frequently include dispensing errors. Dispensing errors may include, for example, providing the wrong drug, strength, quantity, or dosing regimen; not identifying potential drug interactions; or mislabelling drugs. The *Advice to the Profession: Prescribing Drugs* includes information on what to do in the case of a medication incident.

Physicians can minimize errors when dispensing drugs by instituting standardized dispensing procedures (including labelling, instructions, and documentation), using a

checklist or other mechanisms to ensure the dispensing process is accurately completed and correct drug dispensed, and using technology to assist with enhancing workflow.

Council Motion

Motion Title	*Dispensing Drugs* - Draft Policy for Consultation
Date of Meeting	June 16, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy “Dispensing Drugs”, (a copy of which forms Appendix “ “ to the minutes of this meeting).

Council Briefing Note

June 2022

Topic:	Update on Council Elections
Purpose:	For Information
Relevance to Strategic Plan:	Meaningful Engagement
Public Interest Rationale:	Ensuring that Council has qualified and diverse members to enable the College to carry out its strategic objectives and fulfill its mandate to serve the public interest
Main Contacts:	Caitlin Ferguson, Governance Coordinator

Issue

- Council is provided with an update on the current Council election cycle.

Background

- The 2022 Council Elections are being held in the following districts:
    - **District 1:** 1 position
      Counties of Essex, Kent, and Lambton
    - **District 2:** 1 position
      Counties of Elgin, Huron, Middlesex, Oxford, and Perth
    - **District 3:** 1 position
      Counties of Bruce, Dufferin, Grey, Wellington, and the Regional Municipality of Waterloo
    - **District 4:** 2 positions
      County of Brant and the Regional Municipalities of Haldimand-Norfolk, Halton, Hamilton-Wentworth, and Niagara

- Nominations opened on Friday March 11, 2022 with the distribution of the Notice of Election, and closed on Friday April 22, 2022 at 4:00pm.

- The Governance Committee reviewed the Conflict of Interest forms and nomination statements. All candidates standing for election meet the eligibility criteria set out in legislation and by-law.

- A total of 9 nomination submissions were received. The nominees are:

    - District 1: Dr. David Adekoya (86082) and Dr. Andrea Steen (60867)

    - District 2: Dr. Robert Gratton (60909)

    - District 3: Dr. Baraa Achtar (105910)

    - District 4: Dr. Ian Preyra (73607), Dr. Waël Hanna (92094), Dr. Carys Massarella (62129), Dr. Crispen Richards (77892), and Dr. Sangita Sharma (75188).

Current Status and Analysis

- Elections opened on May 31, 2022 in District 1 (one position, two candidates) and District 4 (two positions, five candidates). The voting period will end on June 21, 2022.

- District 2 (Dr. Robert Gratton) and District 3 (Dr. Baraa Achtar) are both acclaimed.

Next Steps

- Following the close of elections, the successful candidates will be announced the week of June 27th 2022.

- Successful nominees will be onboarded before the December Council meeting, in preparation for their upcoming role.

Council Briefing Note

June 2022

Topic:	Proposed Register By-law Amendments
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement Continuous Improvement
Public Interest Rationale:	Accountability: Holding regulated health professionals accountable to their patients/clients, the College and the public Protection: Ensuring the protection of the public from harm in the delivery of health care services
Main Contact(s):	Marcia Cooper, Senior Corporate Counsel & Privacy Officer
Attachment(s):	Appendix A: Proposed Amendments to General By-law Appendix B: Explanation of Proposed Amendments

Issue

- Amendments to the General By-Law are proposed to add and amend certain information displayed on the CPSO public register.

Current Status and Analysis

- In March 2022, Council approved the circulation of the proposed by-law amendments to the profession.
- The circulation period was over on March 15, 2022, and no comments were received.
- The amendments are shown in Appendix A; the redlining indicates the changes to the current By-law provisions.
- An explanation of the amendments is set out in Appendix B.

Questions for Council

1. Does Council approve of the proposed by-law amendments?

Appendix A

Proposed Amendments to General By-law

Re Register Provisions

Redlining indicates the changes to the current By-law provisions.

Content of Register Entries

49. (1) In addition to the information required under subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following information with respect to each member:

…

12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations and ~~,~~ relinquishments of the member's privileges or practice, and rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect.

13. If an allegation of professional misconduct or incompetence against the member has been referred to the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal and not yet decided,
    i. a summary of the allegation if it was referred to the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal prior to September 10, 2013,
    ii. a summary of the allegation and/or the notice of hearing if it was referred to the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal after September 10, 2013,
    iii. an indication that the matter has been referred to the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal,
    iv. the anticipated date of the hearing, if the date has been set,
    v. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of the adjournment, and
    vi. if the decision is under reserve, that fact.

14. If the result of a disciplinary proceeding in which a finding was made by the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register,
    i. the date on which the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal made the finding, ~~and~~
    ii. the date on which the ~~discipline committee~~Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty, and~~.~~
    iii. if the finding is appealed, the status of the appeal and the disposition of the appeal.

…

17. If an application ~~to the discipline committee~~ for reinstatement has been ~~scheduled~~referred to the Ontario Physicians and Surgeons Discipline Tribunal,
    i. that fact,
    ~~i.~~ii. the dates on which the application is scheduled to be heard,

ii.iii. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of that adjournment, and

iii.iv. if the decision is under reserve, that fact.

17.1 If an application to the discipline committeeOntario Physicians and Surgeons Discipline Tribunal for reinstatement has been decided, the decision of the discipline committeeOntario Physicians and Surgeons Discipline Tribunal.

…

17.3 If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed,

i. that fact,

ii. the dates on which the application is scheduled to be heard,

iii. if the hearing has been adjourned and no future date has been set, the fact of that adjournment, and

iv. if the decision is under reserve, that fact.

17.4 If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

Public Information

50.1 (1) All information contained in the register, other than:

…

g. if,

(i) terms, conditions or limitations were directed to be imposed upon a member's certificate of registration by a committee other than the discipline committeeOntario Physicians and Surgeons Discipline Tribunal, and

(ii) the terms, conditions or limitations have been removed,

the content of the terms, conditions or limitations are no longer public information.

Appendix B

Explanation of Proposed Amendments
From March 2022 Council Briefing Note

1. **Hospital Privileges and Voluntary Leaves of Absence: By-law s. 49(1)12 (revision)**

- Hospitals[1] are required to provide a written report to CPSO if they have revoked, suspended or imposed restrictions on the member's privileges, for reasons of professional misconduct, incompetence or incapacity. (*Health Professions Procedural Code* s. 85.5(1))
- In addition, hospitals (and the other persons listed in the footnote) are required to provide a written report to CPSO if a member has resigned, or voluntarily relinquished or restricted their privileges or practice:
    a) where the hospital reasonably believes this is related to the member's professional misconduct, incompetence or incapacity, or
    b) during the course of or as a result of an investigation by the hospital into allegations of misconduct, incompetence or incapacity. (Code, s. 85.5(2))
- The *Public Hospitals Act* (s. 33) requires similar mandatory reporting.
- The General By-law (s. 49(1)12) provides that the information in these mandatory reports are to be posted on the public register.
- The wording of the By-law is broad and would include a leave of absence voluntarily taken by a member in the context of such allegations or in the face of a hospital investigation.
- We had occasion to recently consider posting a voluntary leave of absence taken by a member while the hospital sorted out a matter. The hospital had sent a mandatory report about this to CPSO. After discussions, it was thought that it may create a deterrent for a member to take a voluntary leave of absence in situations where this approach might be helpful and conducive to resolving the issues at the hospital. While CPSO would still get the report and be able to monitor or follow up as necessary, it may not be important to advise the public of the leave of absence.
- I note that what is proposed is a carve-out for voluntary leaves of absence only. CPSO would continue to post a member's resignation in face of an investigation, for example, and also suspensions and revocations of a member's hospital privileges. This would be in keeping with hospital expectations that these would be posted to make the public aware of changes in a physician's privileges at their facility.

2. **Appeals of Tribunal Findings: By-law s. 49(1)14 (revision)**

- Where findings of the Discipline Committee (Tribunal) are appealed, the Code (s. 23(2)16) requires a notation that the findings under appeal are to be posted on the register until the appeal is finally disposed of.
- It has been CPSO's practice to also include information about the status of the appeal and the disposition of the appeal on the register, and to keep that information on the register.
- We recommend that there be a by-law amendment to reflect this practice and clearly indicate the authority for including this additional information.

[1] This also applies to employers, other persons who offer privileges to a member, or are associates (partners) of members for the purpose of offering health services. The written report is also required if such an employer or associate terminates the member's employment or dissolves a partnership or other association with a member for reasons of professional misconduct, incompetence or incapacity.

3. **Reinstatement Applications: By-law s. 49(1)17 (revision)**

- The General By-law provides for certain information to be posted about applications by former members to have their certificate of registration reinstated with CPSO.
- Currently, the fact of the application for reinstatement is to be posted once a hearing has been scheduled.
- David Wright has suggested that the applications be posted at an earlier time, once they have been referred to the Tribunal by the Registrar (in accordance with the Code and the Tribunal Rules).

4. **Applications to Vary Tribunal Orders: By-law s. 17.3 and 17.4 (new)**

- Under Rule 16 of the OPSDT's Rules of Procedure, a member can apply to the Tribunal to have an order varied, suspended or cancelled on the grounds of facts arising or discovered after the order was made.
- David Wright suggested that these applications should be noted on the register to inform the public that a member is seeking to have an order changed, and indicate if an application is denied or advise of changes in terms, conditions or limitations if the application is allowed.
- This is largely consistent with the practice of posting applications for reinstatement, already provided for in the General By-law.

5. **References to Discipline Committee in By-law s. 49(1) and s. 50.1 (revision)**

- The references to the discipline committee in Sections 49(1) and 50.1 of the General By-law are proposed to be changed to refer to the Tribunal.
- This is a housekeeping change.
- Note that similar changes were made at March Council to other provisions in the General By-law that are not required to be circulated to the profession before they can be enacted.

Council Motion

Motion Title	Register By-law Amendments
Date of Meeting	June 16, 2022

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. 148:

By-law No. 148

(1) Paragraphs 12, 13, 14, 17, and 17.1 of subsection 49(1) of the General By-law are revoked and substituted with the following:

Content of Register Entries

49. (1) In addition to the information required under subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following information with respect to each member:

…

12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations and relinquishments of the member's privileges or practice, and rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect.

13. If an allegation of professional misconduct or incompetence against the member has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided,

    i. a summary of the allegation if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to September 10, 2013,
    ii. a summary of the allegation and/or the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal after September 10, 2013,
    iii. an indication that the matter has been referred to the Ontario Physicians and Surgeons Discipline Tribunal,

iv. the anticipated date of the hearing, if the date has been set,
v. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of the adjournment, and
vi. if the decision is under reserve, that fact.

14. If the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register,
i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding,
ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty, and
iii. if the finding is appealed, the status of the appeal and the disposition of the appeal.

…

17. If an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal,
i. that fact,
ii. the dates on which the application is scheduled to be heard,
iii. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of that adjournment, and
iv. if the decision is under reserve, that fact.

17.1. If an application to the Ontario Physicians and Surgeons Discipline Tribunal for reinstatement has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

(2) Subsection 49(1) of the General By-law is amended by adding the following as paragraphs 17.3 and 17.4:

17.3. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed,
i. that fact,
ii. the dates on which the application is scheduled to be heard,
iii. if the hearing has been adjourned and no future date has been set, the fact of that adjournment, and
iv. if the decision is under reserve, that fact.

17.4. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

(3) Paragraph (g) of subsection 50.1(1) of the General By-law is amended by deleting the reference to “discipline committee” and substituting it with “Ontario Physicians and Surgeons Discipline Tribunal”.

Council Briefing Note

June 2022

Topic:	Audited Financial Statements for the 2021 Year
Purpose:	For Decision
Main Contact(s):	Dr. Thomas Bertoia, Chair, Finance and Audit Committee Ms. Nathalie Novak, Chief Operating Officer Mr. Douglas Anderson, Corporate Services Officer Ms. Leslee Frampton, Manager, Finance
Attachment(s):	Appendix A: Draft Audited Financial Statements for the Year Ended December 31, 2021

Issue

- Audited Financial Statements – Year ended December 31, 2021
- Appointment of the Auditor for the 2022 fiscal year

Background

- Mr. Mike Rooke, of Tinkham LLP Chartered Professional Accountants, reviewed the audited financial statements for the year ended December 31, 2021 for the Finance and Audit Committee.

- Mr. Rooke reported that the financial statements are represented fairly and in accordance with Canadian accounting standards for not-for-profit organizations. The reports states:

  "In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2021, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations."

- The Finance and Audit Committee made the following motions:

  The Finance and Audit Committee recommends to Council that the audited Financial Statements for the year ended December 31, 2021, be accepted as presented by Tinkham LLP Chartered Professional Accountants.

  The Finance and Audit Committee recommends to Council $2,470,040 of the unrestricted net assets as of December 31, 2021 be transferred to the capital asset

reserve and that $1,980,899 of the unrestricted net assets as of December 31, 2021 be transferred to the Intangible Asset Fund.

The Finance and Audit Committee recommends to Council that the firm of Tinkham LLP Chartered Professional Accountants be appointed as the College's auditors for the fiscal year 2022.

- The auditor also stated that the College has excellent internal controls and they did not have any recommendations to improve internal controls or accounting procedures as a result of the application of their audit procedures. As well, the auditor told the Committee that the College's books were in top-notch shape.

Questions for Council

1. Does Council approve the audited financial statements for the year ended December 31, 2021 as presented?
2. Does Council approve the recommendation that the firm of Tinkham LLP Chartered Professional Accountants be reappointed as the College's auditors for the year 2022?

Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2021

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Members of the
College of Physicians and Surgeons of Ontario

We have audited the accompanying financial statements of the College of Physicians and Surgeons of Ontario ("College"), which comprise the statement of financial position as at December 31, 2021 and the statements of operations and changes in unrestricted net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2021, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College’s financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

TORONTO, Ontario
June 16, 2022

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Financial Position

As at December 31	**2021**	2020
Assets		
Current		
Cash	**$ 58,578,305**	$ 57,723,392
Accounts receivable	**1,903,588**	1,626,007
Prepaid expenses	**1,573,129**	1,143,913
	62,055,022	60,493,312
Investments (note 3)	**50,331,712**	50,000,000
Capital assets (note 4)	**16,828,346**	14,976,974
	$129,215,080	$125,470,286
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 9,208,460**	$ 9,222,798
Current portion of obligations under capital leases (note 7)	**689,167**	837,439
	9,897,627	10,060,237
Deferred revenue (note 5)	**33,240,949**	33,250,440
	43,138,576	43,310,677
Accrued pension cost (note 6)	**5,256,150**	5,319,798
Obligations under capital leases (note 7)	**316,093**	786,489
	48,710,819	49,416,964
Net assets		
Internally restricted (note 8)		
Invested in capital assets	**15,823,086**	13,353,046
Building Fund	**60,700,276**	60,700,276
Intangible Asset Fund	**3,980,899**	2,000,000
Pension remeasurements	**(1,284,280)**	(1,173,107)
Unrestricted	**1,284,280**	1,173,107
	80,504,261	76,053,322
	$129,215,080	$125,470,286

Commitments and contingencies (notes 9 and 10, respectively)

Approved on behalf of the Council

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See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Unrestricted Net Assets

Year ended December 31	2021	2020 (note 12)
Revenue		
Membership fees		
General and educational (note 5)	**$ 67,443,326**	$ 66,676,837
Penalty fee	**563,126**	1,026
	68,006,452	66,677,863
Application fees	**8,837,479**	7,933,273
OHPIP annual and assessment fees (note 5)	**1,440,239**	939,982
IHF annual and assessment fees (note 5)	**1,431,792**	1,243,292
OHPIP, IHF application fees and penalties	**62,525**	39,914
Cost recoveries and other income	**2,290,504**	1,913,672
Interest income	**553,628**	680,745
	82,622,619	79,428,741
Expenses		
Staffing costs (schedule I)	**51,707,598**	47,358,543
Per diems (schedule II)	**7,869,158**	7,086,960
Other costs (schedule III)	**7,805,729**	6,824,997
Professional fees (schedule IV)	**4,886,444**	3,649,353
Depreciation of capital assets	**3,503,959**	1,874,590
Occupancy (schedule V)	**2,629,811**	2,373,431
	78,402,699	69,167,874
Excess of revenue over expenses before undernoted items	**4,219,920**	10,260,867
Investment income	**342,192**	2,059,268
Excess of revenue over expenses for the year	**4,562,112**	12,320,135
Unrestricted net assets, beginning of year	**1,173,107**	689,281
Less: Invested in capital assets (net)	**(2,470,040)**	(5,382,680)
Less: Transfer to Building Fund	**-**	(4,453,629)
Less: Transfer to Intangible Asset Fund	**(1,980,899)**	(2,000,000)
Unrestricted net assets, end of year	**$ 1,284,280**	$ 1,173,107

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Cash Flows

Year ended December 31	2021	2020
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 4,562,112**	$ 12,320,135
Depreciation of capital assets	**3,503,959**	1,874,590
	8,066,071	14,194,725
Net change in non-cash working capital items:		
Accounts receivable	**(277,581)**	(365,916)
Prepaid expenses	**(429,216)**	688,507
Accrued interest receivable	**(331,712)**	1,375,478
Accounts payable and accrued liabilities	**(14,338)**	(1,251,026)
Deferred revenue	**(9,491)**	391,793 //
Pension cost	**(174,821)**	(140,796)
Cash provided by operating activities	**6,828,912**	14,892,765
Cash flows used by investing activities:		
Purchase of capital assets	**(5,137,442)**	(6,381,823)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(836,557)**	(875,447)
Net increase in cash	**854,913**	7,635,495
Cash, beginning of year	**57,723,392**	50,087,897
Cash, end of year	**$ 58,578,305**	$ 57,723,392

See accompanying notes to the financial statements. 6

1 Organization

College of Physicians and Surgeons of Ontario ("College") was incorporated without share capital as a not-for-profit organization under the laws of Ontario for the purpose of regulating the practice of medicine to protect and serve the public interest. Its authority under provincial law is set out in the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code under RHPA and the Medicine Act.

The College is exempt from income taxes.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

(a) Cash

Cash includes cash deposits held in an interest bearing account at a major financial institution.

(b) Investments

Guaranteed investment certificates are carried at amortized cost.

(c) Capital assets

The cost of a capital asset includes its purchase price and any directly attributable cost of preparing the asset for its intended use.

When conditions indicate a capital asset no longer contributes to the College's ability to provide services or that the value of future economic benefits or service potential associated with the capital asset is less than its net carrying amount, its net carrying amount is written down to its fair value or replacement costs. As at December 31, 2021, no such impairment exists.

(i) Tangible assets

Tangible assets are measured at cost less accumulated amortization and accumulated.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Furniture and fixtures	10 years	Computer equipment under capital lease	2 - 4 years

(ii) Intangible assets

Intangible assets, consisting of separately acquired computer application software, are measured at cost less accumulated amortization.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated useful lives of four years.

2 Significant accounting policies (continued)

(d) Pension plans

(i) Healthcare of Ontario Pension Plan

Healthcare of Ontario Pension Plan ("HOOPP") is a multi employer best five consecutive year average pay defined benefit pension plan.

Defined contribution accounting is applied to HOOPP and contributions are expensed when due.

(ii) CPSO Retirement Savings Plan 2019

CPSO Retirement Savings Plan 2019 is a defined contribution plan. Contributions are expensed when due.

(iii) Designated Employees' Retirement Plan for the College of Physicians and Surgeons on Ontario

The College maintains a closed (1998) defined benefit pension plan and supplementary arrangements for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

The College recognizes its defined benefit obligations as the employees render services giving them right to earn the pension benefit. The defined benefit obligation at the statement of financial position date is determined using the most recent actuarial valuation report prepared for accounting purposes. The measurement date of the plan assets and the defined benefit obligation is the College's statement of financial position date.

In its year-end statement of financial position, the College recognizes the defined benefit obligation, less the fair value of plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized in the excess of revenues over expenses for the year. Past service costs resulting from changes in the plan are recognized immediately in the excess of revenue over expenses for the year at the date of the changes.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation allowance in the case of a net defined pension asset; past service costs; and gains and losses arising from settlements or curtailments. Remeasurements are recognized as a direct charge (credit) to net assets.

(e) Revenue recognition

(i) Members' fees and application fees

These fees are set annually by Council and are recognized as revenue proportionately over the fiscal year to which they relate. Fees received in advance are recorded as deferred revenue.

(ii) Independent Health Facility (IHF) and Out of Hospital Premises Inspection Program (OHPIP) fees

IHF and OHPIP annual and assessment fees are recognized at the same rate as the related costs are expensed.

(iii) Cost recoveries

Cost recoveries are recognized at the same rate as the related costs are expensed.

(iv) Other income

Other income is recognized as the services are provided, the amount is known and collection is reasonably assured.

2 Significant accounting policies (continued)

(e) Revenue recognition (continued)

(v) Interest and investment income

Interest income is comprised of interest on cash deposits held in an interest bearing account at a major financial institution. Investment income is comprised of income on guaranteed investment certificates.

Interest and investment income are recognized when earned. Income on guaranteed growth investment certificates is determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest is accrued at the minimum guaranteed rates.

(f) Financial instruments

(i) Measurement

The College initially measures its financial assets and financial liabilities at fair value, adjusted by, in the case of a financial instrument that will not be measured subsequently at fair value, the amount of transaction costs directly attributable to the instrument.

The College subsequently measures its financial assets and liabilities at amortized cost. Transaction costs are recognized in income in the period incurred.

(ii) Impairment

At the end of each reporting period, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the period in the expected timing or amount of future cash flows from the financial asset.

(g) Management estimates

In preparing the College's financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expenses during the period. Actual results may differ from these estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

(h) Internally restricted reserves

Council has established the following internally restricted reserves:

(i) Invested in capital assets which comprises the net book value of capital assets less the related obligations under capital leases;

(ii) Building Fund which comprises assets restricted for future building requirements; and

(iii) Intangible Asset Fund which comprises assets restricted for future information technology infrastructure development and improvements.

3 Investments

As at December 31	**2021**	2020
Guaranteed Investment Certificates (GIC)		
Bank of Montreal (BMO) Extendible GIC	**$ 25,000,000**	$ -
National Bank of Canada (NBC) Canadian Banks Portfolio Flex GIC	**25,000,000**	-
Accrued interest	**331,712**	-
Cash	**-**	50,000,000
	$ 50,331,712	$ 50,000,000

The BMO Extendible GIC earns interest at 1.45% and has an initial maturity date of February 1, 2022. The issuer has the option to extend the maturity date in six month increments on the initial maturity date and on each extended maturity date thereafter extending to August 1, 2027.

The NBC Canadian Bank Portfolio Flex GIC matures on January 29, 2026 and earns a return determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. At maturity the principal amount of $25,000,000 is guaranteed. The fair market value of the GIC as at December 31, 2021 is $24,212,500.

4 Capital assets

As at December 31	**2021**		2020	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Tangible assets				
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**21,101,419**	**16,639,886**	21,089,134	16,136,035
Furniture and fixtures	**4,571,754**	**4,155,683**	4,493,281	4,014,251
Computer and other equipment	**1,984,487**	**1,951,546**	1,943,244	1,936,762
Computer equipment under capital lease	**4,038,383**	**3,033,123**	3,839,472	2,215,544
Intangible assets				
Computer application software	**11,122,247**	**2,352,609**	6,116,805	345,273
	44,961,193	**28,132,847**	39,624,839	24,647,865
Net book value		**$ 16,828,346**		$ 14,976,974

5 Deferred revenue

Deferred revenue consists of membership fees received in advance for the next year as well as unearned fees related to the Independent Health Facility program (IHF) and Out of Hospital Premises Inspection Program (OHPIP). The change in the deferred revenue accounts for the year is as follows:

	Membership Fees	IHF	OHPIP	2021 Total	2020 Total
Balance, beginning of year	**$ 28,267,320**	**$ 3,421,627**	**$ 1,561,493**	**$ 33,250,440**	$ 32,858,647
Amounts billed during the year	**67,821,299**	**1,403,006**	**1,081,561**	**70,305,866**	69,251,904
Less: Recognized as revenue	**(67,443,326)**	**(1,431,792)**	**(1,440,239)**	**(70,315,357)**	(68,860,111)
Balance, end of year	**$ 28,645,293**	**$ 3,392,841**	**$ 1,202,815**	**$ 33,240,949**	$ 33,250,440

The IHF and OHPIP Programs are budgeted and billed on a cost recovery basis.

6 Employee future benefits

(a) Designated Employees' Retirement Plan and Supplementary Arrangements

(i) Reconciliation of funded status of the defined benefit pension plan to the amount recorded in the statement of financial position

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Plan assets at fair value	**$ 2,698,132**	**$ -**	**$ 2,698,132**	$ 2,845,069
Accrued pension obligations	**(3,689,691)**	**(4,264,591)**	**(7,954,282)**	(8,164,867)
Funded status - deficit	**$ (991,559)**	**$ (4,264,591)**	**$ (5,256,150)**	$ (5,319,798)

(ii) Pension plan assets

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Fair value, beginning of year	**$ 2,845,069**	**$ -**	**$ 2,845,069**	$ 2,951,102
Interest income	**62,592**	**-**	**62,592**	88,533
Return on plan assets (excluding interest)	**112,592**	**-**	**112,592**	125,409
Employer contributions	**-**	**291,856**	**291,856**	290,099
Benefits paid	**(322,121)**	**(291,856)**	**(613,977)**	(610,074)
Fair value, end of year	**$ 2,698,132**	**$ -**	**$ 2,698,132**	$ 2,845,069

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(iii) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Balance, beginning of year	$ 3,790,392	$ 4,374,475	$ 8,164,867	$ 7,927,870
Interest cost on accrued pension obligations	83,389	96,238	179,627	237,836
Benefits paid	(322,121)	(291,856)	(613,977)	(610,074)
Actuarial losses	138,031	85,734	223,765	609,235
	$ 3,689,691	$ 4,264,591	$ 7,954,282	$ 8,164,867

The most recent actuarial valuation of the pension plan for funding purposes was made effective December 31, 2018. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2021. The valuation of the pension plan for funding purposes as at December 31, 2021 is in progress as of the date of the statements.

(iv) The net expense for the College's pension plans is as follows:

	2021	2020
Funded defined benefit plan	$ 20,797	$ 22,718
Unfunded supplementary defined benefit plan	96,238	126,585
Defined contribution plan	708,993	966,883
Healthcare of Ontario Pension Plan	3,019,898	2,514,591
	$ 3,845,926	$ 3,630,777

(v) The elements of the defined benefit pension expense recognized in the year are as follows:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Interest cost on accrued pension obligations	$ 83,389	$ 96,238	$ 179,627	$ 237,836
Interest income on pension assets	(62,592)	-	(62,592)	(88,533)
Pension expense recognized	$ 20,797	$ 96,238	$ 117,035	$ 149,303

(vi) Remeasurements and other items recognized as a direct charge (credit) to net assets are as follows:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Actuarial losses	$ 138,031	$ 85,734	$ 223,765	$ 609,235
Return on plan assets (excluding interest)	(112,592)	-	(112,592)	(125,409)
Charge to net assets	$ 25,439	$ 85,734	$ 111,173	$ 483,826

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(vii) Actuarial assumptions

The significant actuarial assumptions adopted in measuring the accrued pension obligations as at December 31 are as follows:

	2021	2020
Discount rate	**2.70 %**	2.20 %

(b) Healthcare of Ontario Pension Plan

Employer contributions made to the plans during the year by the Institute total $3,019,898 (2020 - $2,514,591). These amounts are included in staffing costs in the statement of operations.

Each year an independent actuary determines the funding status of HOOPP by comparing the actuarial value of invested assets to the estimated present value of all pension benefits that members have earned to date. The most recent actuarial valuation of the Plan as at December 31, 2021 indicates the Plan is 120% funded. HOOPP's statement of financial position as at December 31, 2021 disclosed total pension obligations of $85.9 billion with net assets at that date of $144.4 billion indicating a surplus of $28.5 billion.

(c) Restructuring benefits

The College restructured its affairs during the year for the purpose of achieving long-term savings, which resulted in severance benefits to employees in the amount of $2,006,829 (2020 - $2,266,872), which has been included in staffing costs.

7 Obligations under capital leases

The College has entered into capital leases for computer equipment. The following is a schedule of the future minimum lease payments over the term of the leases:

2022	$	688,733
2023		278,356
2024		38,171
		1,005,260
Less: current portion		689,167
	$	316,093

8 Internally restricted net assets

2021	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	**$ 13,353,046**	**$ 2,000,000**	**$ 60,700,276**	**$ (1,173,107)**
Excess (deficiency) of revenue over expenses for the year	**(3,503,959)**	**-**	**-**	**-**
Transfer to Intangible Asset Fund	**-**	**1,980,899**	**-**	**-**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(111,173)**
Transfer to Invested in Capital Assets	**5,973,999**	**-**	**-**	**-**
Balance, December 31	**$ 15,823,086**	**$ 3,980,899**	**$ 60,700,276**	**$ (1,284,280)**

2020	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	$ 7,970,366	$ -	$ 56,246,647	$ (689,281)
Excess (deficiency) of revenue over expenses for the year	(1,874,590)	-	2,059,268	-
Transfer to Intangible Asset Fund	**-**	8,116,805	-	-
Actuarial remeasurement for pension	-	-	-	(483,826)
Transfer to Invested in Capital Assets	7,257,270	(6,116,805)	-	-
Transfer to Building Fund	-	-	2,394,361	-
Balance, December 31	$ 13,353,046	$ 2,000,000	$ 60,700,276	$ (1,173,107)

The College has transferred $nil (2020 - $2,394,361) to the building fund and $1,980,899 (2020 - $2,000,000) to the Intangible Asset Fund from unrestricted net assets.

Net assets invested in capital assets is calculated as follows:

As at December 31	**2021**	2020
Net book value of capital assets	**$ 16,828,346**	$ 14,976,974
Less: obligations under capital leases	**(1,005,260)**	(1,623,928)
	$ 15,823,086	$ 13,353,046

9 Commitments

The College has a lease for additional office space which extends to February 28, 2023 with two options to renew for additional five year terms subsequent. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each year of the current term are estimated as follows:

2022	$ 717,083
2023	464,875
Total	$ 1,181,958

10 Contingencies

The College has been named as a defendant in lawsuits with respect to certain of its members or former members. The College denies any liability with respect to these actions and no amounts have been accrued in the financial statements. Should the College be unsuccessful in defending these claims, it is not anticipated that they will exceed the limits of the College's liability insurance coverage.

11 Financial instruments

General objectives, policies and processes

Council has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash, accounts receivable and investments.

Credit risk associated with cash and investments is mitigated by ensuring that these assets are invested in financial obligations of major financial institutions.

Accounts receivable are generally unsecured. This risk is mitigated by the College's requirement for members to pay their fees in order to renew their annual license to practice medicine. The College also has collection policies in place.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows and holding assets that can be readily converted into cash, so as to meet all cash outflow obligations as they fall due.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and equity risk.

(i) Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College is not exposed to foreign exchange risk.

(ii) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investments and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested, provides for a high degree of liquidity, and achieves a satisfactory investment return giving consideration to risk. The College has mitigated exposure to interest rate risk.

(iii) Equity risk

Equity risk is the uncertainty associated with the valuation of assets arising from changes in equity markets. The College is not exposed to this risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

12 Comparative figures

Certain comparative figures have been reclassified to conform to the presentation adopted in the current year.

Schedule I - Staffing costs

Year ended December 31	2021	2020
Salaries	**$ 41,679,796**	$ 37,932,316
Employee benefits	**4,741,440**	5,162,553
Pension (note 6)	**3,845,926**	3,630,777
Training, conferences and employee engagement	**1,297,111**	479,431
Professional association fees	**143,325**	153,466
	$ 51,707,598	$ 47,358,543

Schedule II - Per diem

Year ended December 31	2021	2020
Attendance	**$ 2,270,282**	$ 1,878,678
Preparation time	**2,895,023**	2,722,037
Decision writing	**1,208,111**	1,030,050
Teleconference	**658,763**	642,998
HST on per diems	**425,620**	378,951
Travel time	**411,359**	434,246
	$ 7,869,158	$ 7,086,960

Schedule III - Other costs

Year ended December 31	2021	2020
Credit card service charges	**$ 1,628,051**	$ 1,540,401
Software	**2,382,274**	1,445,462
Equipment leasing	**104,998**	89,030
Equipment maintenance	**33,104**	5,378
Miscellaneous	**753,716**	522,978
Photocopying	**131,200**	221,515
Printing	**6,641**	2,962
Postage	**94,050**	98,159
Members dialogue	**360,445**	296,598
Courier	**26,200**	24,789
Telephone	**408,998**	269,185
Office supplies	**115,203**	514,652
Reporting and transcripts	**461,481**	263,872
FMRAC membership fee	**454,578**	454,528
Publications and subscriptions	**164,444**	185,741
Meals and accommodations	**195,328**	348,616
Travel	**169,542**	208,921
Grants	**74,000**	38,244
Survivors fund	**241,476**	293,966
	$ 7,805,729	$ 6,824,997

Schedule IV - Professional fees

Year ended December 31	**2021**	2020
Consultant	**$ 3,723,378**	$ 2,109,316
Legal	**916,475**	1,471,356
Audit	**77,061**	53,901
Recruiting	**169,530**	14,780
	$ 4,886,444	$ 3,649,353

Schedule V - Occupancy

Year ended December 31	**2021**	2020
Building maintenance and repairs	**$ 878,364**	$ 871,572
Insurance	**723,127**	592,234
Realty taxes	**112,793**	108,101
Utilities	**167,515**	159,937
Rent	**748,012**	641,587
	$ 2,629,811	$ 2,373,431

Council Motion

Motion Title	Approval of the Audited Financial Statements for fiscal year 2021
Date of Meeting	June 16, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2021 as presented (a copy of which form Appendix “ ” to the minutes of this meeting).

Council Motion

Motion Title	Appointment of the Auditors (for fiscal year 2022)
Date of Meeting	June 16, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next financial meeting of the Council.

Council Briefing Note

June 2022

Topic:	Changes to the Fees and Remuneration By-law
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Main Contact(s):	Dr. Thomas Bertoia Chair, Finance and Audit Committee Ms. Nathalie Novak, Chief Operating Officer Mr. Douglas Anderson, Corporate Services Officer Ms. Leslee Frampton, Manager, Finance
Attachment(s):	Appendix A: Draft Amendments to the Fees & Remuneration By-Law

Issue

- Council and Committee Physician Compensation

Background

- A Physician Compensation Working Group (PCWG) was established as a subgroup of the Finance and Audit Committee in 2017 and charged with responsibility to review and develop recommendations for a sustainable compensation model for physician members of Committees and Council.

- The PCWG recognized that the system of compensating physicians on College committees and Council had not been reviewed in many years. It was originally established to cover the costs of a physician's office overhead while performing work for the College. Changes to physician remuneration in Ontario and the long period of time that had passed without a review, suggested a need to look at modernizing the College's approach to physician compensation.

- Based on this review, the PCWG recommended changes to the compensation model for physician members of Council and Committees including establishing the Travel Time rate at 75% of the hourly rate and the introduction of the president's stipend.

- In 2021 in recognition of the importance of physician's time particularly practicing physicians' time, it was determined that Council and Committee members should charge for the actual amount of time spent or scheduled (whichever is longer) on any given day in meetings with the College, without a six-hour limit. It was also determined this time would be inclusive of a lunch hour. It was also determined that the need to differentiate between

telephone or electronic means of which minutes are taken is no longer necessary as meetings are regularly conducted via electronic means.

- At the February meeting of the Executive Committee, the Committee requested the Finance and Audit Committee review some of the additional rules with the current compensation model, particularly the requirement to deduct the first hour of travel time and the limit of only being able to charge for a maximum 3 hours per one way. This would compensate for the actual time spent on College business which mirrors the ability to charge for actual time spent in attendance. Travel time and travel expenses would be subject to review for reasonableness. As well, the Finance and Audit Committee was asked to review the rate for travel time at 75% of the hourly rate for attendance and consider moving this to the full hourly rate.

Recommendations

- The Finance and Audit Committee reviewed the Executive Committee's request and is recommending the following:
    - To allow physician members to charge for either actual time spent, or time scheduled for the meeting, whichever is longer.
    - To allow physician members to charge for **ACTUAL** time spent travelling to the meeting.
    - To move the Travel Time rate to 100% of the current hourly rate for meeting attendance.

- By-law amendments have been proposed to reflect the above changes. See Appendix A for the proposed by-law amendments.

- The proposed by-law amendments also include the change to an hourly compensation for Council and committee members instead of a half-day rate, to reflect current payment practices. The half-day rate was based on the hourly rate now indicated in the proposed amendments, so there is no change to the rate of remuneration. As Council and Committee members can now charge for the actual time spent, the half-day rate is not applicable.

- The proposed by-law amendments also remove the language differentiating between meetings attended in person or via telephone or electronic means, as per the note above.

Questions for Council

1. Does Council agree to allow physician members to charge for either actual time spent, or time scheduled for the meeting, whichever is longer?
2. Does Council agree to allow physician members to charge for actual time spent travelling to the meeting?
3. Does Council agree to move the Travel Time rate to 100% of the current hourly rate for meeting attendance?

APPENDIX A

PROPOSED AMENDMENTS TO FEES AND REMUNERATION BY-LAW

COUNCIL AND COMMITTEE REMUNERATION

20. (1) In this section, "committee" includes a special committee, task force or other similar body established by the council or the executive committee by resolution.

(2) Nothing in this section applies to a person appointed to the council by the Lieutenant Governor in Council or to an employee of the College.

(3) The amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour .

~~(a) for attendance at, and preparation for, meetings to transact College business, $534 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.~~

(4) The amount payable to members of the council and a committee for travel to or from home, or both, in connection with the conduct of council or committee business ~~is a maximum of three hours per one way trip at a rate equal to 75% of the hourly rate corresponding to~~ the hourly rate set out in subsection 20(3)~~(a). No member shall charge the College for the first hour travelled on each portion of the trip.~~

(5) *[repealed: December 5, 2013]*

(6) The amount payable to members of the council and a committee in reimbursement of expenses incurred in the conduct of the council's or committee's business is,

(a) for travel by common carrier, the member's actual cost for economy air fare or VIA 1 train fare, ~~and transportation to and from the airports, stations or other terminals, or~~

Commented [MC1]: Common carrier does not just mean by airline – it refers to transportation of passengers (or goods) for a fee. So I have combined train and air here.

~~(b) for travel by VIA 1 if the train fare does not exceed the economy air fare or, if travelling the evening before conducting College business, if the cost of the train fare plus the hotel room does not exceed the economy air fare,~~

(b) ~~or~~ the member's actual cost of transportation to and from airports, stations or other terminals, if applicable,

(c) for travel by automobile, the member's reasonable automobile expenses, consistent with applicable Canada Revenue Agency rules and guidelines in effect from time to time, and

(d~~e~~) for overnight accommodation and related ~~maintenance (including~~ meals~~)~~ away from home, the actual amount reasonably spent up to such maximum amount set by the College from time to time, for each day away from home for both accommodation and ~~maintenance~~ meals.

(7) No person shall be paid under this section except in accordance with properly submitted vouchers or receipts.

(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.

Council Motion

Motion Title	By-law Amendments to Fees and Remuneration By-law
Date of Meeting	June 16, 2022

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. 149:

By-law No. 149

(1) Subsections 20(3), (4) and (6) of By-law No. 2 (the Fees and Remuneration By-law) are revoked and substituted with the following:

Council and Committee Remuneration

20. … (3) The amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour.

(4) The amount payable to members of the council and a committee for travel to or from home, or both, in connection with the conduct of council or committee business is the hourly rate set out in subsection 20(3).

(6) The amount payable to members of the council and a committee in reimbursement of expenses incurred in the conduct of the council's or committee's business is,

(a) for travel by common carrier, the member's actual cost for economy air fare or VIA 1 train fare,

(b) the member's actual cost of transportation to and from airports, stations or other terminals, if applicable,

(c) for travel by automobile, the member's reasonable automobile expenses, consistent with applicable Canada Revenue Agency rules and guidelines in effect from time to time, and

(d) for overnight accommodation and related meals away from home, the actual amount reasonably spent up to such maximum amount set by the College from time to time, for each day away from home for both accommodation and meals.

(2) Subsection 20(8) is amended by deleting the reference to “subsection 20(3)(a)” and substituting it with “subsection 20(3)”.

Council Briefing Note

June 2022

Topic:	*Decision-Making for End-of-Life Care* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement
Public Interest Rationale:	Aligning the current policy with recent case law while setting clear expectations and guidance for physicians on how to (1) provide quality care to patients at the end of life, and (2) exercise professional judgment while considering and respecting patient wishes, values, and beliefs.
Main Contact(s):	Lynn Kirshin, Senior Policy Analyst Rachel Bernstein, Policy Analyst
Attachment(s):	Appendix A: Draft *Decision-Making for End-of-Life Care* policy Appendix B: Draft *Advice to the Profession: End-of-Life Care* document

Issue

- CPSO's *Planning for and Providing Quality End-of-Life Care* policy is currently under review. A new draft policy, titled *Decision-Making for End-of-Life Care* (**Appendix A**), has been developed with a companion *Advice to the Profession* (*Advice*) document (**Appendix B**).

- Council is asked whether the draft policy can be released for external consultation and engagement.

Background

- The *Planning for and Providing Quality End-of-Life Care* policy was last fully reviewed in 2013 to 2015. During the policy review process, significant changes were made to align the policy with two decisions: a landmark Supreme Court of Canada decision, *Cuthbertson v. Rasouli* (*Rasouli*)[1], which determined that in Ontario consent is required to withdraw life-

[1] *Cuthbertson v. Rasouli*, 2013 SCC 53.

sustaining treatments, as well as a decision from the Health Professions Appeal and Review Board, which directed CPSO to require physicians to obtain consent prior to writing a "do not resuscitate" (DNR) order.

- Revisions were subsequently made in 2019, informed by the Ontario Superior Court decision, *Wawrzyniak v. Livingstone* (*Wawrzyniak*),[2] which clarified physicians' obligations with respect to the writing of DNR orders and the provision of cardiopulmonary resuscitation (CPR).

- Ongoing feedback suggests there are challenges regarding the practical implementation of the expectations related to DNR orders, or "no cardiopulmonary resuscitation" (no-CPR) orders, and concern that CPSO did not fully align the policy with *Wawrzyniak*.

- The current policy review kicked off at December 2020 Council with an interactive presentation and discussion meant to shape and inform the direction of the review.

- Feedback on the current policy was solicited through a preliminary consultation[3] and various other engagement activities, including a virtual discussion with the Citizen Advisory Group (CAG) and public polling, which were undertaken to understand how the public feels about physicians making decisions regarding CPR and writing no-CPR orders, and what could increase comfort when no-CPR orders are written.

- The draft policy was developed with direction from the Policy Review Working Group[4] and was informed by the consultation feedback and research.[5] Additional support was provided by Jessica Amey (Legal Counsel) and Benjamin Chen (Medical Advisor).

[2] *Wawrzyniak v. Livingstone*, 2019 ONSC 4900.
[3] The consultation, which commenced in December 2020, received a total of 122 responses: 16 through written feedback and 106 through the online survey.[3] The majority of respondents were physicians. All feedback has been posted on a dedicated page of CPSO's website and an overview of the feedback was provided in the Policy Report to Council in June 2021.
[4] The composition of the Working Group who started this policy review included Council Members Brenda Copps, Janet van Vlymen, Sarah Reid, Karen Saperson, Peter Pielsticker, and Lydia Miljan, and CPSO Medical Advisor Keith Hay. Brenda Copps, Janet Van Vlymen, and Peter Pielsticker transitioned off the Working Group in April 2022, and Council Members Camille Lemieux, Rupa Patel, and Fred Sherman transitioned onto the Working Group and began working on the review in March 2022.
[5] In addition to engagement activities, an extensive review was undertaken in accordance with the usual policy review process, including a literature review; jurisdictional scan; review of decisions from the Inquiries, Complaints and Reports Committee; and feedback received from Physician Advisory Services and the Patient & Public Help Centre.

Current Status and Analysis

A. Draft *Decision-Making for End-of-Life Care* Policy

- The draft policy has been redesigned to make it more concise and focus solely on end-of-life care decisions and the discussions that inform those decisions.
    - To that end, the title of the draft policy has been updated from *Planning for and Providing Quality End-of-Life Care* to *Decision-Making for End-of-Life Care*.
    - Some of the expectations in the current policy have been moved to the *Advice*, while other expectations have not been retained at all (which resulted in reducing the word count by 41%).[6]
- An overview of the key features of the draft policy is set out below.

Revisions Regarding Advance Care Planning and Goals of Care Discussions

- In response to feedback received from various stakeholders, public polling, and the CAG, the draft policy clarifies the differences between, and emphasizes the importance of, advance care planning and goals of care discussions. The draft policy also strengthens the expectations of the current policy, which do not explicitly address goals of care discussions, and which only "advise" physicians to discuss the importance/benefits of advance care planning.
    - To that end, the draft policy requires physicians to determine whether it is appropriate to initiate an advance care planning discussion depending on a patient's illness or medical condition, and where possible, to initiate goals of care discussions when providing care to patients who are palliative, receiving non-curative treatment, or at risk of clinical deterioration in the foreseeable future. (Provisions #1-2)

Balancing End-of-Life Decision-Making

- Reflecting the importance of applying an equity, diversity, and inclusion lens to end-of-life care decisions, the draft policy includes a broad, principle-based expectation requiring physicians to seek to balance their medical expertise and patient wishes, values, and beliefs whenever making decisions about end-of-life care. (Provision #3)

[6] The following sections/expectations were removed from the draft policy: consent to treatment, palliative care, aggressive pain management and palliative sedation, dying at home, certification of death, wishes and requests to hasten death, documentation, and organ and tissue donation.

Revisions Regarding Withdrawing Potentially Life-Sustaining Treatment

- In keeping with *Rasouli*, the draft policy retains the requirement that physicians must obtain consent before withdrawing life-sustaining treatment. (Provision #4)

- The draft policy also adopts new terminology, requiring physicians to try to resolve "disagreements" rather than "conflicts" or engage in a "conflict resolution process," as the Working Group felt that the current terminology was potentially inflammatory and erroneously signaled that there was a formal process that physicians must follow when withdrawing potentially life-sustaining treatment. (Provision #5)

    - In response to consultation feedback, the draft policy also includes new expectations that require physicians to manage disagreements by making reasonable efforts to support the patient's physical comfort and emotional, psychological, and spiritual well-being, and providing reassurance that the patient will continue to receive all other clinically appropriate care. (Provision #5)

    - The draft policy also contains an expectation that requires physicians to determine whether to apply to the consent and capacity board (CCB) when disagreements arise with a substitute decision-maker, as the current policy's expectation (which "advised" physicians to apply to the CCB) required updating in light of the policy redesign process where only mandatory expectations are set out in policies. (Provision #6)

Revisions Regarding Withholding Resuscitative Measures

- The draft policy completely reconceptualizes the framework with respect to withholding resuscitative measures, including but not limited to CPR. The aim of the revisions is to strike a balance that both supports physician professional judgment and respects the diversity of patient values regarding these important end-of-life decisions.

- To modernize the draft policy, changes have been made to the terminology used, more specifically, adopting "resuscitative measures" instead of "CPR" and "DNR orders" instead of "no-CPR orders".

- The remaining revisions were made to address practical challenges with the current policy and to more fully align the draft policy with the *Wawrzyniak* decision, which clarified that where a physician determines it is not within the standard of care to provide resuscitative measures, such as CPR, to a patient, a physician is *not* required to obtain consent prior to withholding resuscitative measures and/or writing a DNR order.

    - The draft policy expressly states that physicians are not required to obtain consent prior to withholding resuscitative measures and/or writing DNR orders.

  - Recognizing that physicians may consider a range of factors when deciding to withhold resuscitative measures and write DNR orders, and that some factors are more subjective than others, the draft policy sets out different expectations depending on the reasons a physician determines it would be inappropriate to provide resuscitative measures to a patient. This is in keeping with both the literature and guidance offered by other Canadian medical regulators.

- Where providing resuscitative measures would be medically futile (i.e., no intervention could successfully resuscitate the patient), the draft policy enables physicians to write a DNR order, but requires them to inform the patient and/or substitute decision-maker of the order "at the earliest opportunity."[7] (Provision #7)

  - The new expectations are a departure from the current policy, which requires physicians to inform the patient and/or substitute decision-maker *before* writing an order, and give physicians more discretion with respect to informing patients because medical futility is as close as possible to a value free "objective" view of futility.

- Where the risks of providing resuscitative measures would outweigh the potential benefits (i.e., even if the patient could be resuscitated in the immediate term, it would cause them more harm than good), the draft policy enables physicians to write a DNR order, but requires them to first consider the individual patient's wishes, values, and beliefs as part of the risk-benefit calculation and to inform the patient and/or substitute decision-maker of the DNR order *before* writing one. (Provisions #8-9)

  - The draft policy does carve out an exception, permitting physicians to instead inform the patient and/or substitute decision-maker "at the earliest opportunity" when there is an imminent need to write a DNR order. For clarity, the draft policy also contains a provision that prohibits physicians from writing a DNR order when there is any doubt about the result of the risk-benefit calculation. (Provisions #10-11)

- In light of the *Wawrzyniak* decision, physicians do not need to wait for a patient and/or substitute decision-maker to agree before writing DNR orders, and therefore do not need to "manage" or try to resolve disagreements that arise. Therefore, the draft policy has been reframed from resolving conflicts to focusing on providing patients and/or substitute decision-makers with support, for example by offering supportive services, where appropriate and available. (Provision #12)

[7] The *Advice* explains that while physicians are not required to inform the patient and/or substitute decision-maker of the DNR order before it is written in this scenario, it is good practice to do so, where possible.

B. Draft *Advice to the Profession* Document

- In keeping with CPSO's commitment to Right-Touch regulation, some of the content found in the current policy (issues related to dying at home, certification of death, and documentation) has been moved to the draft *Advice*.

- The draft *Advice* is also meant to facilitate a better understanding of the expectations set out in the draft policy, and provides links to additional resources that may be helpful to physicians and patients.

Next Steps

- Pending Council's approval, the draft policy and *Advice* 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.

Questions for Council

1) Does Council approve the draft *Decision-Making for End-of-Life Care* policy for external consultation and engagement?

Decision-Making for End-of-Life Care

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.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Advance care planning discussions: Conversations that take place between health-care providers and capable patients, and where possible, substitute decision-makers, which enable patients to reflect on and communicate their personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, including which treatment(s) they may want at the end of life. The aim of these discussions is to prepare patients and/or substitute decision-makers for future decision-making.

Do Not Resuscitate (DNR) order: A written order in a patient's medical record that provides instructions to the health-care team regarding which resuscitative measures should not be performed if the patient experiences a cardiac or respiratory arrest. DNR orders can be all-encompassing, i.e., "no resuscitative measures," and may be referred to by other names, such as "do not attempt resuscitation" (DNAR) orders, "no-cardiopulmonary resuscitation" (no-CPR) orders, and "do not intubate" orders.[1]

Goals of care discussions: Conversations that take place between health-care providers, patients and/or substitute decision-makers, in the context of a serious illness when there are treatment or care decisions that need to be made in the foreseeable future. The aim of these discussions is to educate patients and/or substitute decision-makers about available treatment options; help define obtainable goals of care by identifying the patient's personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, if they can be ascertained; and align treatment options accordingly through the process of shared decision-making.

[1] Although DNR orders may also include limiting what life-sustaining measures are offered, for the purposes of this policy, DNR orders pertain to resuscitative measures only.

Life-sustaining treatment: Any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or replace a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, vasopressors and inotropes, etc.).

Medical futility: A term used to describe treatment that would not achieve its physiologic goal (e.g., with respect to resuscitative measures, treatment that would not provide oxygenated blood flow to the heart and brain).

Resuscitative measures: A suite of medical interventions, including chest compressions, artificial ventilation, intubation and/or defibrillation, that may be provided following cardiac or respiratory arrest in an attempt to restore or maintain cardiac, pulmonary, and circulatory function. Not all interventions in the suite will necessarily be provided or required in all cases.

Substitute decision-maker (SDM): A person, or persons, who may give or refuse consent to a treatment on behalf of an incapable person.[2]

Policy

Advance Care Planning and Goals of Care Discussions

1. Physicians who provide care as part of a sustained physician-patient relationship **must** determine whether, based on the patient's illness or medical condition, it is appropriate to initiate an advance care planning discussion, and if so:
    a. raise end-of-life care issues with the patient; and
    b. encourage the patient to discuss those issues with their SDM.

2. Physicians who provide care to patients who are palliative, receiving non-curative treatment, or at risk of clinical deterioration in the foreseeable future **must**, where possible:
    a. initiate a timely goals of care discussion (particularly when the risk of a cardiac or respiratory arrest is foreseeable), which involves:
        i. describing the underlying illness or medical condition and prognosis;
        ii. educating the patient and/or SDM about the available treatment options, which may include resuscitative measures, and explaining the outcomes that can and cannot be achieved; and
        iii. defining the patient's goals of care by helping the patient and/or SDM identify the patient's wishes, values and beliefs, or if they cannot be ascertained, identifying what would be in the patient's best interests;

[2] For more information on substitute decision-makers, please see the College's *Consent to Treatment* policy.

b. facilitate the goals of care discussion to help build consensus about what treatment decision(s) need to be made; and
c. review the goals of care discussion with the patient and/or SDM whenever it is appropriate to do so (e.g., when there is a significant change in the patient's medical condition or when the patient and/or SDM indicate that the patient's wishes, values, and/or beliefs have changed).

End-of-Life Care

3. Physicians **must** seek to balance medical expertise and patient wishes, values, and beliefs when making decisions about end-of-life care.

Withdrawing Potentially Life-Sustaining Treatment

4. Physicians **must** obtain consent from patients and/or SDMs before withdrawing life-sustaining treatment.[3]
    a. As part of the consent process, physicians **must**:
        i. explain why they are proposing to withdraw life-sustaining treatment; and
        ii. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

Managing Disagreements

5. Where consent cannot be obtained and the physician is of the view that life-sustaining treatment should be withdrawn, the physician **must** try to resolve the disagreement with the patient and/or SDM in a timely manner by:
    a. communicating information regarding the patient's diagnosis and/or prognosis, treatment options, and assessments of those options;
    b. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
    c. reassuring the patient and/or SDM that the patient will continue to receive all other clinically appropriate care or treatment(s);
    d. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, etc.) and consultation with the patient's family physician, where appropriate and available;
    e. offering to make a referral to another health-care provider and facilitating obtaining a second opinion, where appropriate and available;
    f. offering consultation with an ethicist or ethics committee, where appropriate and available; and

[3] The Supreme Court of Canada determined in *Cuthbertson v. Rasouli, 2013 SCC 53* (hereinafter *Rasouli*) that consent must be obtained prior to withdrawing life-sustaining treatment.

g. taking reasonable steps to transfer care of the patient to another facility or health-care provider, if possible, and only when all appropriate and available methods of resolving disagreements have been exhausted.[4]

6. Physicians **must** determine whether to apply to the Consent and Capacity Board when:[5]
    a. in relation to treatment decisions, disagreements arise with an SDM over an interpretation of a wish, or assessment of the applicability of a wish, or if no wish can be ascertained, what is in the best interests of the patient; or
    b. they are of the view that an SDM is not acting in accordance with their legislative requirements.[6]

Withholding Resuscitative Measures

A physician's decision to withhold resuscitative measures is not "treatment" and therefore does not require the patient or SDM's consent.[7]

A physician may decide that providing resuscitative measures is not appropriate for a patient in situations where they determine that:

- providing resuscitative measures would be medically futile (i.e., no intervention can successfully resuscitate the patient)[8]; or
- the risks of providing resuscitative measures outweigh the potential benefits (i.e., even if the patient could be resuscitated in the immediate term, it would cause them more harm than good).[9]

7. When a physician determines that providing resuscitative measures to a patient would be medically futile, the physician can write a DNR order in the patient's medical record but **must**, at the earliest opportunity (and, if possible, before the DNR order is written):

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[4] In following such a course, physicians must comply with the College's *Ending the Physician-Patient Relationship* policy.

[5] In *Rasouli,* the Supreme Court of Canada determined that when SDMs refuse to provide consent to withdraw life-support that, in the physician's opinion, is not in the patient's best interests, physicians must apply to the Consent and Capacity Board for a determination of whether the SDM has met the substitute decision-making requirements of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (hereinafter *HCCA*) and whether the refused consent is valid. See in particular paragraph 119 of *Rasouli*.

[6] Please see footnote 2.

[7] In *Wawrzyniak v. Livingstone*, 2019 ONSC 4900, the Court concluded that the writing of a DNR order and withholding of cardiopulmonary resuscitation (CPR) do not fall within the meaning of "treatment" in the *HCCA*. Accordingly, consent is not required prior to writing a DNR order and withholding resuscitative measures, such as CPR, and physicians are only required to provide resuscitative measures in accordance with the standard of care.

[8] The concept of medical futility is as close as possible to a value free, "objective," view of futility.

[9] This risk-benefit calculation involves subjective value judgments.

a. inform the patient and/or SDM that an order will be or has been written;
b. explain to the patient and/or SDM why resuscitative measures are not appropriate; and
c. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

8. Before determining that resuscitative measures will not be provided because the risks of providing those interventions would outweigh the potential benefits, the physician **must** consider the patient's wishes, as well as their personal, cultural, and religious/spiritual values and beliefs, if they can be ascertained and/or the physician is aware of them.

9. When a physician determines that the risks of providing resuscitative measures would outweigh the potential benefits, the physician can write a DNR order in the patient's medical record but **must**, before writing the order:
   a. inform the patient and/or SDM that the order will be written;
   b. explain to the patient and/or SDM why resuscitative measures are not appropriate, including the risks of providing those interventions and the likely clinical outcomes if the patient is resuscitated; and
   c. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

10. When a patient's condition is deteriorating rapidly and there is an imminent need for an order to be written (e.g., actual or impending cardiac or respiratory arrest), the physician can write a DNR order in the patient's record but **must** comply with the expectations set out in provision 9 at the earliest opportunity.

11. When a physician is not able to determine whether the risks of providing resuscitative measures would outweigh the potential benefits, the physician **must not** write a DNR order in the patient's medical record unless the patient and/or SDM requests or agrees to it.

Providing Support if Disagreements Arise

12. If the patient and/or SDM disagree with the writing of a DNR order, the physician can write the order, but **must**, at the earliest opportunity after learning of the disagreement, make reasonable efforts to provide support to the patient and/or SDM by:
   a. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
   b. reassuring the patient and/or SDM that the patient will continue to receive all other clinically appropriate care or treatment(s);
   c. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering

supportive services (e.g., social work, spiritual care, etc.), where appropriate and available; and

d. taking reasonable steps to transfer care of the patient to another facility or health-care provider, if possible and requested by the patient and/or SDM.[10]

[10] Please see footnote 4.

Advice to the Profession: End-of-Life Care

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.

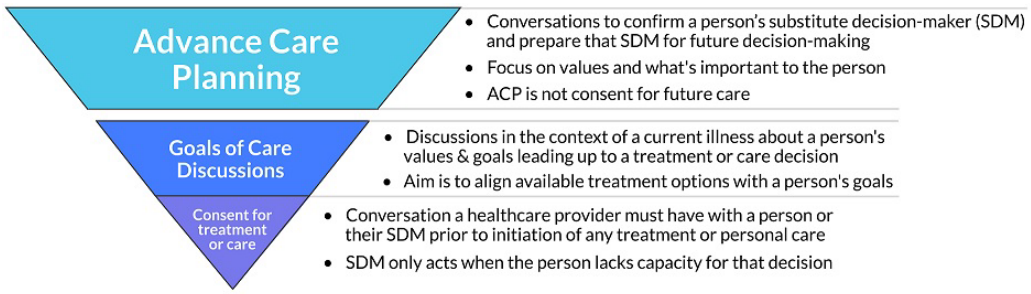
This document provides guidance on how the obligations set out in the *Decision-Making for End-of-Life Care* policy can be effectively discharged. This document also provides physicians with guidance on other specific end-of-life care issues, such as medical certificates of death and dying at home.

Advance Care Planning and Goals of Care Discussions

What are the differences between advance care planning and goals of care discussions? If I have these discussions, do I still need to obtain consent for treatment?

The main difference between advance care planning and goals of care discussions is the context of the decision-making: where advance care planning discussions take place earlier and help prepare patients and their substitute decision-makers for future decision-making, goals of care discussions occur in the context of a serious illness when there are treatment or care decisions that will soon need to be made, and help inform which treatment options may be provided.

As illustrated in the diagram below from Hospice Palliative Care Ontario's "Speak Up" campaign, neither advance care planning nor goals of care discussions constitute consent. An advance care planning discussion may outline information about the prior capable wishes of a patient and may be used to guide substitute decision-makers in providing informed consent, but it does not constitute consent to treatment. Similarly, a goals of care discussion will often lead to the development of a plan of treatment, but it does not constitute consent to treatment. Accordingly, even if you have these discussions, you will need to obtain consent from your patient or their substitute decision-maker in order to provide treatment.



What are the benefits of having timely advance care planning and goals of care discussions? What resources can I use or direct my patients to?

Having timely end-of-life care discussions can, among other things:

- lead to improved patient outcomes and quality of life;
- inform treatment decisions and ensure that the care provided aligns with the patient's wishes, as well as their personal, cultural and religious/spiritual values and beliefs;
- lessen family distress;
- increase patient comfort with physicians making decisions to write Do Not Resuscitate (DNR) orders;
- decrease hospitalizations and admissions to critical care, as well as potentially harmful or overly aggressive interventions and treatments;
- encourage realistic treatment goals; and
- help ensure the health-care team is not urgently rushing to have last-minute conversations during an emergency, for example, when a patient is experiencing a cardiac or respiratory arrest.

It is important for physicians to take an active role in helping patients and/or substitute decision-makers identify meaningful and realistic goals of care that seek to incorporate the patient's – not the substitute decision-maker's – wishes, values, and beliefs. Patients and/or substitute decision-makers may need some assistance articulating these wishes, and physicians can help them engage in this process by providing necessary medical information and opportunity for discussion.

The following websites may be helpful:

- Advance Care Planning Canada has resources and tools to assist both physicians and patients in making decisions regarding end-of-life care.
- Speak Up Ontario offers an advance care planning workbook tailored to patients receiving care in Ontario.
- Choosing Wisely Canada also has resources to help both physicians and patients get started in having end-of-life discussions.

When should I be initiating advance care planning discussions?

The policy requires physicians who provide care as part of a sustained physician-patient relationship to determine whether, based on the patient's illness or medical condition, it is appropriate to initiate an advance care planning discussion (for example, when there is a reasonable possibility that decisions will have to be made about the provision of life-sustaining treatment). That said, it is never too early for physicians to have advance care planning discussions with their patients. As part of routine care, physicians may discuss the importance and benefits of advance care planning; choosing a substitute

decision-maker; documenting and disseminating advance care plans to substitute decision-makers and health-care providers; and reviewing these plans throughout life.

When significant life events or changes in the patient's medical status occur, physicians can also remind patients of the importance of this process and encourage patients who have already engaged in advance care planning to evaluate existing care plans.

Why might it be important to involve family members and/or others close to the patient in discussions about the patient's care?

Family and/or others close to the patient can act as intermediaries; ask clarifying questions; and help patients to better understand their diagnoses, prognoses, and medications, any tests that may be required, as well as the decisions they have to make about treatment options. Involving family and/or others close to the patient in the ongoing care of a patient can also result in patients receiving more effective care and support at home and can mitigate caregiver distress.

It is important to ensure that consent is obtained to disclose personal health information about the patient whenever a patient and/or substitute decision-maker wishes to involve others in the patient's care.

Should I be documenting advance care planning and goals of care discussions?

Yes. In keeping with the College's *Medical Records Documentation* policy, physicians must document every encounter with a patient and/or substitute decision-maker and all patient-related information. In the end-of-life context, this means that physicians must document references to discussions and decisions regarding treatment, goals of care, and advance care planning, and explicitly and clearly reference when a Do Not Resuscitate (DNR) order has been placed in the patient's record.

Potentially Life-Sustaining Treatment

Can I offer potentially life-sustaining treatment to patients on a trial basis? How would that work?

Yes. There are times where the outcomes of a potentially life-sustaining treatment are uncertain, and in these instances, proposing a trial of treatment allows for the exploration of a possibly positive outcome.

When offering a trial of treatment, it is important to explain to the patient and/or substitute decision-maker which outcomes would warrant continuation and discontinuation of the treatment. It is also important to explain that when the patient and/or substitute decision-maker provide consent to the trial of treatment, they may provide consent to discontinue the treatment at a later stage if it proves ineffective.

Providing consent to discontinue the treatment up front is helpful because it eliminates the need to formally get consent from the patient and/or substitute decision-maker to stop the trial of treatment down the road.

That said, once the treatment has been initiated, patients and/or substitute decision-makers can withdraw their consent to any elements of the trial and/or withdraw their consent to discontinue the treatment at any time, and it is important to communicate this to the patient and/or substitute decision-maker. When consent to discontinue the treatment is withdrawn, the disagreement would be managed in accordance with the policy provisions on withdrawing potentially life-sustaining treatment.

What is the role of the Consent and Capacity Board? How do I find more information?

The Supreme Court of Canada[1] has affirmed that the Consent and Capacity Board (CCB) is the appropriate authority to adjudicate disagreements between physicians and substitute decision-makers regarding the withdrawal of life-sustaining treatments. The CCB is an expert tribunal, comprised of lawyers, psychiatrists, and members of the public, and is supported by full-time legal counsel. The CCB has the ability to convene hearings quickly and has the authority to direct substitute decision-makers to make decisions in accordance with a patient's prior capable wishes or best interests.

The CCB can also provide assistance when a physician believes that a substitute decision-maker is not acting in the best interests of a patient, or when clarity is required to determine a patient's wishes, whether a wish applies, or whether a wish was expressed while the patient was capable or at least 16 years of age. The CCB can also grant permission to depart from wishes in very limited circumstances.

The CCB's website (www.ccboard.on.ca) has information regarding their services. Physicians may wish to contact the CCB directly for more assistance or seek assistance from legal counsel, either from their institution, if applicable, or from the Canadian Medical Protective Association.

Withholding Resuscitative Measures

What are the legal requirements regarding withholding resuscitative measures and writing Do Not Resuscitate (DNR) orders?

In August 2019, the Ontario Superior Court released *Wawrzyniak v Livingstone*[2], which clarified that physicians are required to provide cardiopulmonary resuscitation (CPR) to a patient only when doing so is within the standard of care.

[1] In *Cuthbertson v. Rasouli*, 2013 SCC 53.
[2] *Wawrzyniak v. Livingstone*, 2019 ONSC 4900.

Where a physician determines that it is not appropriate to provide resuscitative measures, such as CPR, to a patient (i.e., that it is not within the standard of care), the physician is *not* required to obtain consent from the patient and/or substitute decision-maker prior to withholding resuscitative measures and/or writing a DNR order.

Does the College require physicians to obtain consent before writing a Do Not Resuscitate (DNR) order?

No, in keeping with the court's decision in *Wawrzyniak v Livingstone* (*Wawrzyniak*), the College does not require physicians to obtain consent from a patient and/or substitute decision-maker prior to writing a DNR order.

However, physicians have other professional expectations they must meet when writing DNR orders, and these expectations differ depending on the physician's reason for writing the order, as outlined below.

When providing resuscitative measures to a patient is medically futile

If a physician determines that providing resuscitative measures to a patient is medically futile, the physician – who has the expertise to decide whether treatment simply will not work – can write a DNR order, but the policy requires them to:

- inform the patient and/or substitute decision-maker that an order will be or has been written;
- explain to the patient and/or substitute decision-maker why resuscitative measures are not appropriate; and
- provide details regarding all other clinically appropriate care or treatment(s) they propose to provide, at the earliest opportunity.

The College does not require physicians to inform the patient and/or substitute decision-maker of the DNR order *before* it is written in this scenario, although it is good practice to do so, where possible.

When the risks of providing resuscitative measures to a patient outweigh the potential benefits

There are times where it may be possible to resuscitate a patient, but the physician determines that the risks of providing resuscitative measures outweigh the potential benefits. This risk-benefit calculation involves subjective value judgments. As a result, before making these determinations, the policy requires physicians to consider the patient's wishes, as well as the patient's personal, cultural and religious/spiritual values and beliefs, if they can be ascertained and/or the physician is aware of them. In order to respect the importance of these decisions for patients/families, the policy also requires physicians to do several things *before* writing a DNR order:

- inform the patient and/or substitute decision-maker that the order will be written;
- explain to the patient and/or substitute decision-maker why resuscitative measures are not appropriate, including the risks of providing resuscitative measures and the likely clinical outcomes if the patient is resuscitated; and
- provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

Recognizing that decisions need to be made quickly when a patient's condition deteriorates rapidly, the policy permits physicians to write a DNR order in the patient's record and *subsequently* comply with the expectations set out above where there is an imminent need to write an order. While the policy still requires physicians to consider the patient's wishes, values, and beliefs in these emergent situations, physicians do not have to discuss them with the patient and/or substitution decision-maker if there is no time to do so. However, if the physician is already aware of the patient's wishes, values, and beliefs, they are required to factor them into their decision-making.

When might a physician determine that providing resuscitative measures to a patient is "medically futile"?

Providing resuscitative measures to a patient is "medically futile" when the patient's condition is such that no intervention can successfully resuscitate the patient (i.e., provide oxygenated blood flow to the heart and brain). Some examples of when providing resuscitative measures to a patient might be medically futile include:

- A polytrauma patient has uncorrectable exsanguination where cerebral perfusion cannot be achieved by chest compressions.
- A frail patient has septic shock with progressive multiorgan failure that does not respond to optimal intensive care.
- An elderly patient has severe ischemic cardiomyopathy that is not amenable to a revascularization procedure and now presents with another myocardial infarction and congestive heart failure.

This list is not exhaustive and does not determine what is or is not medically futile. Physicians will need to use their professional judgment on a case-by-case basis to determine whether providing resuscitative measures to a patient could achieve the physiologic goals of resuscitation.

When having discussions with patients and/or substitute decision-makers about withholding resuscitative measures, it is important to keep in mind that it may be more patient-centred to explain that providing resuscitative measures would be "medically inappropriate" or "ineffective" rather than "medically futile."

When might a physician determine that the risks of providing resuscitative measures to a patient outweigh the potential benefits?

A patient's medical condition may be such that even if the patient could be resuscitated in the immediate term, it would cause more harm than good. For example:

- A patient has end-stage dementia and terminal cancer, is not verbal, and cannot eat or drink on their own. Every organ system is failing and it is clear that a cardiac arrest is imminent.
- A patient with advanced, metastatic lung cancer and a profound brain injury with no prospect of neurological recovery experiences a respiratory arrest.

Determining whether the risks of providing resuscitative measures to a patient would outweigh the potential benefits in these scenarios involves considering the patient's medical condition, as well as their wishes, values and beliefs, if they can be ascertained, and then assessing whether, among other things:

- the potential outcome would constitute a success for the patient (e.g., whether success means survival, discharge from intensive care, or discharge from hospital);
- the probability of success is sufficiently high to warrant providing resuscitative measures in light of the risks; and/or
- the patient's quality of life would be tolerable to them if they survived.

It is important that physicians consider how their own values, beliefs, and implicit biases may affect their assessment of whether the risks of providing resuscitative measures to a patient would outweigh the potential benefits. As outlined above, this risk-benefit calculation involves considering matters from the patient's point of view as much as possible.

How can I explain to a patient and/or substitute decision-maker why resuscitative measures are not being offered?

It may be helpful to explain that just as patients would not be offered a surgery or other treatment that is not within the standard of care, patients are not provided resuscitative measures that are not within the standard of care.

The policy requires physicians to inform/reassure the patient and/or substitute decision-maker regarding all other clinically appropriate care or treatment(s) they propose to provide – what does this mean?

As outlined in the policy, physicians may determine that a patient's condition is such that it is appropriate to either withdraw life-sustaining treatment or withhold resuscitative measures. However, it is critical for patients and/or substitute decision-makers to understand that even when that is the case, the patient will not be

abandoned. Rather, the patient will continue to receive all other care or treatment that is clinically appropriate, such as palliative care, surgical procedures that are clinically indicated (e.g., fracture repair), and/or chronic disease management (e.g., diuretic therapy for heart failure).

What happens if there is disagreement about the writing of a Do Not Resuscitate (DNR) order?

Given that physicians are not required to obtain consent before writing a DNR order, they can write an order even if the patient and/or substitute decision-maker disagree. However, physicians must do several things to provide support to the patient and/or substitute decision-maker at the earliest opportunity after learning of a disagreement, as set out in the policy.

In addition, there are other things physicians can do to alleviate distress if a patient and/or substitute decision-maker expresses concern about the writing of a DNR order. For example, it is good practice to review the reasons for the DNR order and consult with another physician, where appropriate.

It is important to note that disagreements between the health-care team and patient/substitute decision-maker regarding DNR orders often relate to misunderstandings about what is involved in providing resuscitative measures, and/or stem from the concern that a DNR order will result in neglect or very limited attention to otherwise treatable conditions unrelated to a cardiac or respiratory arrest. This is why it is important for physicians to review the reasons for the DNR order, as noted above.

One of the types of resuscitative measures patients and/or substitute decision-makers might request is cardiopulmonary resuscitation (CPR). It is helpful to explain that CPR generally has a very low success rate – especially for frail/elderly patients, those who have a critical illness and are in the intensive care unit, and those with serious medical illnesses, like cancer, heart disease or kidney disease – and that the risks of CPR include harmful side effects (e.g., rib fracture, pneumothorax, damage to other internal organs) and adverse clinical outcomes (e.g., brain damage, coma, memory loss, paralysis). If CPR is not successful in providing oxygenated blood flow to the heart and brain, it may mean that the patient dies in an undignified and traumatic manner.

I want to have a conversation with my patient and/or their substitute decision-maker about the patient's resuscitation code status – what should I be discussing?

Physicians can explain that full resuscitation is the default for all patients and that this means the health-care team will use any available resuscitative measure (e.g., chest compressions, artificial ventilation, etc.) to resuscitate a patient if the patient experiences a cardiac or respiratory arrest.

It can also be helpful for physicians to have comprehensive discussions with patients and/or substitute decision-makers about what, if any, interventions the patient might want to receive, and explain that because resuscitative measures include a suite of interventions, it is possible to request only some interventions and not others (e.g., some patients and/or substitute decision-makers may request compressions but not intubation). It is good practice to explain that even if a patient and/or substitute decision-maker request full resuscitation, this request may be overridden in the future if a physician determines that it would not be appropriate to provide any or all resuscitative measures to the patient. It can also be helpful for physicians to explain that if a patient and/or substitute decision-maker request Do Not Resuscitate (DNR) status, the patient will still receive all other medically appropriate care (e.g., a patient with a "do not intubate" order may still be offered a surgery that is clinically indicated and requires intubation).

Patient Death

What can I do for my patients who are receiving end-of-life care and who wish to stay at home as long as possible or die at home?

To help patients and their caregivers (including substitute decision-makers) assess whether home care and/or dying at home are manageable options, at minimum, it is important to speak to them about the following issues:

- patient safety considerations;
- the caregiver's ability to manage the situation; and
- whether the patient will be able to receive the necessary care (e.g., whether 24-hour, on-call coverage is required and available, whether home palliative care physicians or community-based programs are able to assist, etc.).

It is also helpful to speak with patients and their caregivers about what to expect and do, including who to contact, when the patient is about to die or has just died at home.

If a patient has also expressed a wish not to be resuscitated, physicians are advised to order and complete the "Ministry of Health and Long-Term Care Do Not Resuscitate Confirmation Form"[3] and inform the substitute decision-maker and any other caregivers on the importance of keeping the form accessible and showing it to paramedics if they are called. Unless this form is completed and presented, a paramedic is likely to use resuscitative measures and transfer the patient to hospital.

[3] These forms can be ordered by completing and submitting the Government of Ontario's "Forms Order Request." For more information about the "Ministry of Health and Long-Term Care Do Not Resuscitate Confirmation Form," please visit: http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45.

When do I have to certify a patient's death?

The *Vital Statistics Act*[4] requires physicians[5] (and in limited circumstances, nurse practitioners) who have been in attendance during, or have sufficient knowledge of the last illness of a deceased person to complete and sign a medical certificate of death immediately following the death (usually interpreted as within 24 hours following death[6]), unless there is reason to notify the coroner[7].

Completing a medical certificate of death can be logistically difficult, and so it is beneficial for physicians to designate the physician(s) or nurse practitioner(s) who will be available to attend to the deceased in order to complete and sign the medical certificate of death. It is also helpful for physicians to take into consideration any local or community strategies[8] that are in place to facilitate the certification of death.

How do I obtain medical certificates of death?

Physicians are able to access digital versions of the medical certificate of death online in both English and French. Physicians can also order blank hard copies of the medical certificate of death via phone (807-343-7432), fax (807-343-7694), or mail from the Office of the Registrar General, depending on their preference.

[4] Section 35(2) of the R.R.O. 1990, Reg. 1094, General, enacted under the *Vital Statistics Act*, 1990; R.S.O. 1990, c. V.4. The certificate must state the cause of death according to the International Statistical Classification of Diseases and Related Health Problems, as published by the World Health Organization, and be delivered to the funeral director.

[5] Physicians cannot delegate the responsibility of completing and signing medical certificates of death to others (e.g., Physician Assistants).

[6] This may be extended on weekends, holidays and under unusual or special circumstances.

[7] Section 10 of the *Coroners Act*, R.S.O. 1990, c. C.37 requires physicians to immediately notify a coroner or police officer if there is reason to believe that an individual has died: as a result of violence, misadventure, negligence, misconduct or malpractice; by unfair means; during pregnancy or following pregnancy in circumstances that might be reasonably attributed to the pregnancy; suddenly and unexpectedly; from disease or sickness for which they were not treated by a legally qualified medical practitioner; from any cause other than disease; or under circumstances that may require investigation.

[8] Many communities in Ontario have an Expected Death in The Home Protocol.

Council Motion

Motion Title	*Decision-Making for End-of-Life Care* – Draft Policy for Consultation
Date of Meeting	June 16, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, “Decision-Making for End-of-Life Care,” (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

June 2022

Topic:	Proposed Amendments to *Medical Records Management* Policy
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	Proposed amendments support CPSO's ability to fulfill its regulatory duty and clarify physicians' obligations with respect to ensuring CPSO's access to medical records where required.
Main Contact(s):	Tanya Terzis, Senior Policy Analyst Kaitlin McWhinney, Junior Policy Analyst Craig Roxborough, Director, Policy
Attachment(s):	Appendix A: Proposed amendments to *Medical Records Management* policy Appendix B: Proposed amendments to *Advice to the Profession: Medical Records Management* document

Issue

- To address barriers in accessing electronic medical records (EMRs) during the course of College regulatory activities, minor amendments are being proposed to the *Medical Records Management* policy (**Appendix A**) and accompanying *Advice to the Profession: Medical Records Management* document (**Appendix B**) to clarify physicians' obligations in this regard.

- Council is provided with an overview of the proposed amendments and is asked whether the amended policy can be approved as a policy of the College.

Background

- CPSO's *Medical Records* policy was last reviewed and approved by Council in 2020.

- As part of the last review cycle, the policy was reorganized and divided into two separate and retitled policies: *Medical Records Management* which sets out expectations related to the care, handling, and management of medical records, and *Medical Records Documentation* which sets out expectations related to how and what to document in the medical record.

- Both policies are based on relevant legislation and regulatory requirements related to medical record-keeping and set out additional professional expectations for physicians. In particular, *Medical Records Management* articulates expectations related to establishing custodianship and accountabilities, accessibility, and requirements related to EMRs, amongst others.

- Additional guidance is set out in the *Advice to the Profession: Medical Records Management* document and includes considerations when choosing an EMR vendor and responsibilities when engaging commercial services to assist when managing patient medical records.

Current Status and Analysis

- Challenges have recently emerged where some physicians and/or their EMR service providers were unaware of or refused to comply with their obligation to make patient records accessible to CPSO for regulatory purposes.

    - The General Regulation under the *Medicine Act, 1991* requires physicians to make their medical records available for statutory or regulatory inspection (s. 21) and the *Medical Records Management* policy sets out multiple expectations in relation to physicians' obligation to ensure there is access to the records, even when the records are stored with a third party (see for example provisions #25 and #32).

- In response, amendments to the *Medical Records Management* policy and *Advice* document are proposed to clarify and more specifically identify physicians' obligations in this regard.

    - Notwithstanding existing legal obligations and policy provisions, an opportunity exists to provide additional clarity and specificity regarding physicians' obligations when engaging with EMR service providers that more directly address the concerns that have recently been identified.

- A new provision is proposed (see the new provision #31 included in **Appendix A**) that requires physicians to only engage with EMR service providers who are willing and able to make medical records accessible, where required, for the purposes of regulatory processes (e.g., College investigations and assessments) and to ensure that EMR service providers are aware of these obligations (e.g., through a written agreement).

    - The proposed amendments build on existing obligations set out in policy that require physicians to exercise due diligence in the selection of an EMR system and/or EMR service provider (provision #30).

    - Existing expectations require physicians to ensure that use of EMRs will enable them to fulfill their responsibilities under the General Regulation and as set out in both the *Medical Records Management* and *Medical Records Documentation*

policies. The proposed amendments further explicate these obligations to directly address these recent concerns.

- Additional changes to the *Advice* document (**Appendix B**) will be made to help further clarify that when engaging with commercial services offering EMR services, these providers are acting on *behalf* of physicians and physicians will need to ensure that their obligations can be met.

- Given the alignment between the proposed amendments and existing legal and professional obligations, no consultation period is being proposed. Rather, the amendments are being presented for final approval.

- The policy is set to be reviewed in 2025 or 2026 depending on organizational priorities.

Next Steps

- Should Council approve the proposed amendments to the policy, it will be announced in *Dialogue* and added to CPSO's website.

Question for Council

1. Does Council approve the proposed amendments to the *Medical Records Management* policy?

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.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

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:

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[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:

a. the fact of the refusal;
b. the reason for the refusal; and

[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.

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]

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.

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[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.
[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.

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].

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]

[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.
[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.

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]

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

[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.
[31] *PHIPA*, s. 13(1).

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.

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

[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*.
[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.

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:

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. Physicians **must** only engage with EMR service providers who are willing and able to make medical records accessible, where required, for the purposes of regulatory processes (e.g., College investigations and assessments) and **must** ensure that EMR service providers are aware of their obligations in this regard (e.g., through written agreements).

[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.
[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.

32. 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]

33. 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).

Transitioning Records Management Systems[44]

34. 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

[42] *Medicine Act*, General Regulation, s. 20.
[43] *Medicine Act*, General Regulation, s. 20.
[44] For additional guidance related to transitioning record-keeping systems please refer to the companion *Advice to the Profession: Medical Records Management* document.

d. maintain the integrity of the data in the medical record.

35. 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).

36. 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.

37. 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.

38. 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
    b. inform all health care professionals who would reasonably be expected to contribute or rely on the record of this date.

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

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

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

consider the type of system that best meets a physician's unique practice needs, including the following:

- requirements set out in policy and legislation (whether vendor policies are compliant with regulations under the *Medicine Act, 1991*[6] and *PHIPA* and will enable the College access to medical records, when required*),*
- 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

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

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 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 are ultimately responsible for ensuring their professional and legal medical record-keeping obligations are met, including when engaging commercial services to assist with managing their records or record-keeping systems. The same obligations apply when physicians engage commercial providers for services such as information technology functions, storage, maintenance, scanning, destruction, and other medical record-keeping related tasks. To ensure that commercial service providers are aware of their obligations with respect to medical records, 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.

Service providers acting on behalf of physicians are bound by the same rules governing medical records as physicians (e.g., obligations related to privacy, security, and access) and physicians must only engage with service providers who are willing and able to comply with their medical record-keeping obligations, including making records accessible to the College, where required (e.g., College investigations and assessments).[8] Clarifying these obligations when contracting with service providers is important to ensure that physicians are able to fulfill their legal and professional

[8] There may also be other entities that are authorized by statute or regulation to access patient medical records.

obligations. Reviewing existing agreements is also worthwhile and can help ensure compliance with the policy and applicable legislation.

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.[9] 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 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*[10], 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

[9] See IPC Orders HO-009 and HO-14.
[10] 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."

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.

A patient of mine is transferring their care to another physician and that physician has requested a copy of my records. Am I permitted to charge for this service?

Yes. Charging for records in this scenario is permitted because the physician is requesting a copy of the records on behalf of the patient. This is distinct from information sharing that occurs between health care providers within the circle of care. Physicians are not permitted to charge for records transfer that is part of the ongoing provision of care, such as information sharing for the purposes of a consultation.

What are some considerations when determining whether the fees I'm charging are reasonable?

The policy requires physicians who are charging for copying and transferring records to only charge fees that are reasonable, and to not exceed reasonable cost recovery. It requires ensuring fees are commensurate with professional costs of preparing the materials and sending the materials. A number of factors can contribute to decisions about reasonableness, including the size of the file or extent of information being requested, the mode of transfer, whether the records are in digital form or are paper-based. This could all have an impact on the time required to prepare the material and the cost of sending the material. In some cases, the cost of preparing the materials might be quite low and in these cases fees must reflect that.

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 *PHIPA*.[11] Sending records in a method that allows them to be tracked or traced can help to avoid such scenarios.

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

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.[12] As a result, notwithstanding the 10 year retention requirement set out in regulation[13] 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.

Medical Records and Closing a Practice

What are my obligations for medical records when closing my practice?

The College's *Closing a Medical Practice* policy sets outs expectations for physicians who cease to practice due to retirement, resignation, revocation, suspension, illness or death or who relocate to another practice. It includes specific expectations for medical records in these circumstances and can be consulted for further information.

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

[12] Section 15(2) of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B.
[13] 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.

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*.

Council Motion

Motion Title	Medical Records Management Policy – Proposed Amendments
Date of Meeting	June 16, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Medical Records Management", (a copy of which forms Appendix " " to the minutes of this meeting) as a policy of the College.

Council Briefing Note

June 2022

Topic:	*Virtual Care* – Revised Draft Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement
Public Interest Rationale:	Setting clear expectations and guidance for physicians to support access to high quality and safe virtual care.
Main Contact(s):	Tanya Terzis, Senior Policy Analyst Kaitlin McWhinney, Jr. Policy Analyst
Attachment(s):	Appendix A: Revised Draft *Virtual Care* Policy Appendix B: Revised Draft *Advice to the Profession: Virtual Care*

Issue

- CPSO's *Telemedicine* policy is currently under review. A newly titled draft *Virtual Care* policy was released for external consultation in September 2021 along with a companion *Advice to the Profession* document (*Advice*). The draft policy and *Advice* have been revised in light of the feedback received through consultation feedback and engagement activities.

- Council is provided with an overview of the key issues considered by the Policy Review Working Group as well as the proposed revisions and is asked whether the revised draft policy can be approved as a policy of the College.

Background

- The current *Telemedicine* policy was last reviewed and approved by Council in 2014. Following extensive research[1], a Policy Review Kick-off at Council, a preliminary consultation[2], and a Virtual Care Symposium that brought patients and physicians together

[1] This included a literature review; a jurisdictional review of Canadian medical regulatory authorities; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee (ICRC); and feedback on the current policy from CPSO's Registration and Membership Services and the Patient and Public Help Centre.

[2] 220 responses were received in total (21 through the online discussion page, and 199 via the online survey). An overview of the feedback was provided to Council in December 2020 as part of the Policy Report.

to discuss what quality virtual care looks like from both perspectives, a new draft policy was developed based on direction from the Policy Review Working Group[3]. Additional support was provided by Kirk Maijala and Carolyn Silver (Legal Counsel).

- The draft policy was approved for external consultation by Council in September 2021. The accompanying *Advice* was also released at this time.

    - A total of 388 responses were received as part of this external consultation.[4] The majority of responses were from physicians, including almost an equal number of family physicians and specialists. A number of organizational respondents also provided feedback.[5]

    - Given the dramatic transformation in the delivery of healthcare that has occurred during the COVID-19 pandemic, the consultation feedback was clearly informed by these experiences. There was both broad support for virtual care in terms of its potential to promote access, convenience, and safety, as well as significant concerns raised about virtual care inappropriately being prioritized over in-person care. We also heard concerns from key stakeholders regarding the proliferation of virtual walk-in clinics and substandard virtual care more generally.

    - Notwithstanding the concerns raised, there was broad support for the draft policy with a strong majority of survey respondents agreeing that the draft is clear, easy to understand, and that the expectations are reasonable. All feedback can be viewed on the consultation webpage.[6]

- During the consultation period we also met with a number of key stakeholders and internal CPSO groups, including the Canadian Medical Protective Association (CMPA), Ontario Health, and the Inquiries Complaints and Reports Committee.

    - Importantly there was strong support from these groups regarding the draft policy expectations and the principled nature of the policy. External stakeholders confirmed that there is alignment in our approaches.

- An overview of the key revisions made in response to the feedback received during the consultation and engagement activities is set out below.

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[3] At the time consisting of Brenda Copps, Janet van Vlymen, Lydia Miljan, Peter Pielsticker, Sarah Reid, Karen Saperson, and Medical Advisor, Keith Hay.
[4] 66 responses were received through the online discussion page and 322 via the online survey.
[5] Organizational responses included: Addictions and Mental Health Ontario; Alliance for Healthier Communities; Association of Family Health Teams of Ontario (AFHTO); Canadian Medical Protective Association (CMPA); College of Physicians and Surgeons of Alberta (CPSA); Information and Privacy Commissioner of Ontario (IPC); KMH Cardiology Centers; Maple Corporation; Ontario College of Family Physicians (OCFP); Ontario Medical Association (OMA); OMA Section on General & Family Practice (SGFP); OMA Section on Plastic Surgery; OntarioMD; Professional Association of Residents of Ontario (PARO); and The Ottawa Hospital.
[6] A preliminary overview of the feedback was provided to Council in the December 2021 Policy Report.

Current Status and Analysis

- Revisions have been made to both the draft *Virtual Care* policy (**Appendix A**) and *Advice* (**Appendix B**), predominantly in response to feedback obtained during the external consultation and based on direction from the Policy Review Working Group.

- Given the broad support received for many of the draft policy provisions, many of the draft policy expectations have been retained in the revised version, with minor revisions made to enhance clarity or address concerns.

- An overview of the key issues considered by the Policy Review Working Group along with corresponding revisions is set out below.

Key Revisions in Response to Feedback

Patient Preference for In-person or Virtual Care

- In response to significant feedback about the importance of accommodating patient preference for in-person or virtual care where appropriate, the revised draft policy now includes a stand-alone provision that requires prioritizing patient preference where clinically appropriate and available (Provision #5). This revises the draft policy which merely mentioned patient preference among a list of considerations. The *Advice* has been further updated to clarify that physicians are ultimately responsible for determining the modality that will serve the patient's best interest and contains suggestions for how to resolve any disagreements should they arise.

    - The importance of patient choice regarding modality was a dominant theme during the consultation and engagement activities, particularly, that patients who wanted to be seen in-person should be accommodated. There was also feedback from key organizational stakeholders that patient choice cannot supersede quality care.

    - Some patients have experienced great difficulty accessing in-person care during the pandemic which is likely a result of system wide direction regarding a virtual-first approach at different points in the pandemic, as well as some resistance from some physicians to returning to providing in-person care.

    - The new draft provision does not compel physicians to prioritize patient choice for virtual or in-person care where it's clinically inappropriate or unavailable, however it does require that patients are accommodated, where possible.

The ability to provide in-person care when required and virtual walk-in clinics

- There was significant feedback from key stakeholders expressing concerns about completely virtual walk-in clinics and some concerns about substandard virtual care more broadly (e.g., physicians inappropriately diverting patients to emergency departments or

walk-in clinics for in-person assessments, referrals being made without adequate prior assessments, discontinuity of care, etc.). These stakeholders suggested that the policy should require all physicians, including virtual walk-in clinics, to be able to offer, or at least coordinate, in-person care where necessary.

- The Policy Review Working Group considered this issue very carefully and were of the view that the problems that were being identified could be addressed if compliance with existing expectations were met, such as meeting the standard of care and the expectations set out in CPSO's *Walk-in Clinics* policy. Significant updates have been made in both the draft policy and *Advice* to highlight existing expectations that are applicable in this space and to address the concerns raised during the consultation.

    - The expectations related to scenarios requiring in-person care have been updated and strengthened. In particular, the revised draft policy continues to require being mindful of the limitations of virtual care and taking appropriate action when the physician determines that in-person care is required. Appropriate action now includes informing patients of the urgency with which in-person care should be sought and providing or assisting patients in accessing in-person care in a timely manner (e.g., through coverage arrangements or by directing patients to local in-person options) (Provision #7).

    - The revised draft *Advice* emphasizes that the standard of care is often difficult to meet in a completely virtual environment, physicians will generally be required to provide in-person care, and that a fully virtual practice might be possible in only very limited circumstances (e.g., radiology, psychotherapy, etc.).

    - To address concerns raised during the consultation about virtual walk-in clinics and substandard virtual care more broadly (e.g., breakdowns in continuity of care) the revised draft *Advice* emphasizes the existing expectations set out in CPSO's *Walk-in Clinics* policy and the medical record-keeping requirements that are applicable to this space (e.g., providing patients' primary care providers with a record of the encounter in certain circumstances and ensuring documentation is complete and comprehensive, containing pertinent details that may be useful to patients' future healthcare, etc.).

    - The revised draft *Advice* also emphasizes how to meet the standard of care when delivering care virtually (e.g., continuing to obtain a relevant history, conducting appropriate examinations, ordering diagnostic tests, and making diagnoses and/or differential diagnoses, as appropriate and ensuring that patients referred to specialists are appropriately investigated and treated before a referral is made).

- Recognizing that all practices are unique, no practice can address all needs, and that there are some medical services that can arguably meet the standard of care through entirely virtual interactions the Policy Review Working Group decided that it would not be practical or feasible to require every physician to be able to provide in-person care.

- They felt that doing so could actually have unintended consequences for patients who already have trouble accessing care locally (e.g., those in remote or rural communities, patients with addictions and/or mental health issues, patients seeking specialized/culturally appropriate healthcare, patients seeking care when their physicians are unavailable or temporarily absent from practice, etc.). Key considerations in support of this decision included:

    - The current requirement to meet the standard of care sets quite a high bar and the issue we are seeing is more about non-compliance with the standard and not necessarily an issue with the policy itself (i.e., some instances of virtual walk-in clinics providing care that should involve an in-person assessment).

    - As long as the standard of care can be met in the circumstance, the Policy Review Working Group felt it was not reasonable to preclude the provision of this care by adding additional expectations that may not be practical or necessary in all instances.

    - One of the main benefits of virtual care is its potential to overcome geographic barriers and access issues. An expectation requiring all physicians to have an in-person option could inadvertently limit access to (virtual) care in places that are already experiencing access issues.

    - There are many patients in the province without a primary care provider and even those who have one may experience difficulty accessing care, particularly after hours. These services can play a role in triaging or alleviating the need to attend emergency departments for minor issues and shutting them down can have negative consequences for local emergency departments.

    - The revised draft position requiring physicians to assist patients in accessing in-person care options when necessary aligns with expectations in CPSO's *Availability and Coverage* policy which allows physicians to direct patients to access points in the community for after-hours care or during temporary absences from practice (e.g., local walk-in clinics, emergency departments, etc.). This expectation recognizes the challenges some physicians face making specific arrangements for coverage (e.g., those in remote or rural areas where there is already limited access to care).

    - The policy aims to be principle-based and nimble. The standard is in a state of evolution and issues that we might view as needing an in-person assessment today may not need to be seen in-person in the future.

    - Concerns expressed during the consultation are not necessarily unique to virtual care and represent common frustrations about discontinuity of care and a lack of integrated system that are inherent in the health care system more broadly.

Establishing a Physician-Patient Relationship Virtually

- In response to questions about the information physicians need to disclose to patients during a virtual encounter, the revised draft policy now requires physicians to disclose their identity, contact information and licensure status (where they are licensed) to all *new* patients (Provision #6). It also now requires disclosing the identities of all parties present during the virtual encounter (Provision #11c) These expectations broadly align with those of other Canadian medical regulators.

    - The draft policy required physicians to disclose their identities and licensure status to patients located in other jurisdictions (i.e., when providing cross-border virtual care), however the Policy Review Working Group felt that requiring certain information to be disclosed to all *new* patients sets a more appropriate minimum expectation and helps to address instances where the patient might not know which physician will be providing them with virtual care or even who to contact should they have questions or concerns about their care (e.g., virtual walk-in clinics).

Appropriate and Safe Settings to Conduct Virtual Encounters

- To enhance clarity about what it means to conduct virtual care in an appropriate and safe setting, and the actions to take when a setting is deemed inappropriate or unsafe, the following updates have been made in the draft policy:

    - The revised draft policy now requires that where virtual interactions are synchronous, physicians confirm the physical setting where the patient is receiving virtual care is appropriate and safe *in the circumstances (i.e., taking into account the nature and purpose of the intended interaction)* (Provision #9).

    - Where physicians determine that it is not appropriate or safe to proceed, the revised draft requires they take appropriate action, such as re-scheduling the appointment in a timely manner (Provision #9a).

- These revisions reflect that virtual care can take a variety of forms including interactions by video, telephone or digital messaging and that what is appropriate in terms of the patient's setting is really dependent on the nature and purpose of the interaction (e.g., the complexity and/or sensitivity of the conversation or encounter). For example, an appropriate setting for psychotherapy treatment might be different than an appropriate setting to discuss a medication refill.

Obtaining informed consent for the delivery of virtual care

- In response to frequent and consistent requests to provide additional clarity regarding physicians' obligations to obtain consent for the delivery of care virtually, updates have been made in the revised draft policy to clarify the consent provisions. In particular the revised draft policy clarifies that consent must be obtained during the initial virtual encounter and each time the benefits, limitations, and potential risks change (e.g., if the

virtual modality used changes, or if the nature of the care significantly changes) (Provision #14).

- Additional updates have been made in the revised draft *Advice* to clarify that consent can be obtained by someone working on behalf of the physician and that documentation of consent for virtual care is not required in every instance of virtual care. For those who continue to have questions about appropriate consent, the revised draft *Advice* directs physicians to additional resources, such as the CMPA's guidance on consent and the sample disclosure in the Canadian Medical Association's *Virtual Care Playbook*.

Providing Virtual Care Across Borders

- Recognizing that there are many scenarios where a physician might provide virtual care across borders (e.g., an Ontario physician providing care into a bordering province, a physician licensed elsewhere providing care into Ontario, an Ontario patient seeking virtual care while on vacation out of the province, an Ontario physician needing to follow-up with a patient while they are out of the province, etc.), the revised draft policy retains the principled approach articulated in the draft policy. In particular, the revised draft policy requires that:

    - Physicians must be licensed in Ontario when providing virtual care into Ontario, with some exceptions to allow for limited virtual care that serves a patient's best interests; and
    - Where a physician is providing virtual care into another jurisdiction, they must comply with the requirements for licensure in that jurisdiction.

- However, minor revisions were made in the revised draft policy and *Advice* to clarify that:

    - Physicians must ensure they have appropriate liability protection if they provide care into other jurisdictions.

    - From the CPSO's perspective, Ontario physicians can provide necessary virtual care to Ontario patients even when one or the other is temporarily out of the province (i.e., virtual care that supports patient safety, continuity of care, or patient best interests).

    - There are distinct rules for liability protection and billing when providing cross-border virtual care and the CMPA and Ministry of Health should be consulted about these issues. The draft *Advice* also directs physicians to the CMPA's guidance regarding their approach to cross-border virtual care.

- There has been some confusion throughout the review process about the rules around cross-border virtual care, and how CPSO's rules compare to the rules regarding liability protection and billing. A concerted effort has been made to clarify expectations in a variety of cross-border scenarios as well as to emphasize that the rules regarding licensing and professionalism are distinct from rules regarding liability protection and billing. The reality is that these questions are really fact specific and dependent on too many variables to give detailed answers to all situations in the policy or *Advice*.

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Question for Council

1. Does Council approve the revised draft *Virtual Care* policy as a policy of the College?

Virtual Care

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.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Virtual Care: Any interaction between patients and/or members of their circle of care[1] that occurs remotely[2], using any form of communication or information technology, including telephone, video conferencing, and digital messaging (e.g., secure messaging, emails, and text messaging) with the aim of facilitating or providing patient care.[3]

Policy

Virtual care is the practice of medicine

1. When providing virtual care, physicians **must** continue to meet the standard of care and the existing legal and professional obligations that apply to care that is provided in person, including those pertaining to prescribing drugs, medical record-keeping, protecting personal health information, consent to treatment, continuity of care, and charging for insured and uninsured services.[4]

[1] For more information about who is included in the circle of care, please see CPSO's *Protecting Personal Health Information* policy.

[2] Remotely means without physical contact and does not necessarily involve long distances. Patients, patient information and/or physicians may be separated by space (e.g. not in the same physical location) and/or time (e.g. not in real time).

[3] This definition was adapted from Shaw, J., Jamieson, T., Agarwal, P., Griffin, B., Wong, I., & Bhatia, R.S. (2018). Virtual care policy recommendation for patient-centred primary care: findings of a consensus policy dialogue using a nominal group technique. *Journal of Telemedicine and Telecare, 24*(9), 608-615. [4]

Relevant legal obligations include privacy and confidentiality requirements as set out in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (hereinafter *PHIPA*), and General, Ontario Regulation 329/04, enacted under *PHIPA*, consent requirements in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, and mandatory liability coverage in s. 50.2 of the General By-Law. Professional obligations are set out in CPSO's *Practice Guide* and policies.

a. For example, physicians providing virtual care **must** conduct any assessments, tests, or investigations that are required in order for them to appropriately provide treatment and **must** provide or arrange for appropriate follow-up care.[5]

2. Physicians **must** ensure they have the competence to provide care virtually, including to effectively use the relevant technology.

Virtual Care and Patients' Best Interests

Virtual care is not appropriate in every instance as not all conditions can be effectively treated virtually and not every patient has access to or will be comfortable using virtual care technology.

3. Physicians **must:**

a. use their professional judgment to determine whether virtual care is appropriate in each instance its use is contemplated; and
b. only provide virtual care if it is in the patient's best interest to do so. This means only providing virtual care when:

i. the quality of care will not be compromised; or
ii. the potential benefits of providing virtual care outweigh the risks to the patient (e.g., during contagious disease outbreaks or for a patient whose access might be otherwise limited to the point of risking patient harm).[6]

4. When determining whether virtual care is appropriate and in the patient's best interest (i.e., can meet the conditions set out in 3(b) above), physicians **must** consider and ensure their decisions reflect the following factors:

a. the nature of the presenting complaint and care required, including whether a physical examination is required in order to meet the standard of care;
b. the patient's existing health status and specific health-care needs;

[5] For more information on what it means to meet the standard of care when delivering care virtually, please see the *Advice to the Profession: Virtual Care* document.
[6] In some exceptional circumstances it may be appropriate to provide virtual care even when in-person care would generally be required to meet the standard of care. These circumstances are generally limited to instances where virtual care promotes patient or public safety. In these circumstances the potential benefits of patient or public safety override the potential risk to quality of care.

c. the patient's specific circumstances and preferences (e.g., financial hardship, mobility limitations, distance required to travel to an in-person appointment, ability to take time off from work, or any language and/or communication barriers); and
d. the technology available to the patient and their ability to effectively utilize the technology.

5. Where clinically appropriate and available, physicians **must** prioritize patient preference for in-person or virtual care.

Establishing a physician-patient relationship

6. Physicians providing virtual care **must** ensure the following is disclosed to all new patients:

    a. the physician's identity,
    b. the physician's contact information, and
    c. the physician's licensure status (i.e., where they hold a medical licence).

Limitations of Virtual Care and Appropriate Action

7. Physicians **must:**

    a. be mindful of the limitations of virtual care; and
    b. take appropriate action if, during the course of a virtual encounter it is determined that a patient requires in-person care, including:
        i. informing patients of the need for in-person care and the urgency with which it should be sought; and
        ii. providing or assisting patients in accessing appropriate in-person care in a timely manner (e.g., through a coverage arrangement or by directing patients to local in-person options).

8. Physicians **must** take appropriate action if, during the course of a virtual encounter the quality of the encounter becomes compromised (e.g., technology fails or security is compromised) and the patient's best interests will no longer be served by continuing with the virtual encounter, including:

    a. ensuring the patient is followed-up with in a timely manner; and/or
    b. rescheduling the appointment, where necessary.

Appropriate Setting and Technology

9. Where the virtual encounter is synchronous (i.e., involves real-time interaction with the patient), physicians **must** confirm the physical setting where the patient is receiving virtual care is appropriate and safe in the circumstances (i.e., taking into account the nature and purpose of the intended interaction).

    a. Physicians **must** take appropriate action if they determine that it is not appropriate or safe to proceed, such as explaining that they will be unable to proceed at that time and re-scheduling the appointment in a timely manner.

10. Physicians providing virtual care **must** use technology that is fit for purpose, can facilitate a quality encounter, and enables the standard of care to be met, including technology that:

    a. allows physicians to gather the information needed to provide the care; and
    b. supports the sharing of high quality and reliable patient health information (e.g., diagnostic or other images that are of sufficient quality).

Maintaining Privacy, Security, and Confidentiality

The legal obligations to protect the privacy and confidentiality of patients' personal health information (PHI) also exist when delivering virtual care.

11. All physicians **must** take reasonable steps to protect PHI, including protection against theft, loss, and unauthorized access, use, and disclosure of PHI.[7] When providing virtual care, physicians **must**:

    a. take reasonable steps to accurately identify the patient (e.g., verify their name and date of birth);[8]
    b. conduct the encounter in a private setting, where applicable;
    c. disclose the identities of all participants that will be present during the encounter;
    d. ask the patient whether they are in a reasonably private setting and are comfortable discussing or sharing their PHI at that time; and
    e. use secure information and communication technology (e.g., platforms that are protected by encryption), unless it is in the patient's best interest to do otherwise, taking into account:

[7] *PHIPA*, s. 12 (1).
[8] What is reasonable will differ if the encounter takes place within the context of an existing physician-patient relationship compared with a new patient.

- the nature and purpose of the encounter, including the degree of sensitivity of the PHI being shared;
- the availability (or lack thereof) of alternative technology;
- the volume of information and frequency of use;
- patient expectations; and
- any emergency or other urgent circumstances.[9]

12. If using less secure technology (e.g., unencrypted platforms), physicians **must** obtain and document the patient's express (i.e., verbal or written) consent to do so.[10]

Obtaining Informed Consent for Virtual Care

13. Physicians **must** ensure informed consent is obtained from the patient or their substitute decision maker (SDM) for the delivery of care using a virtual modality, which will require informing patients or their SDM of the benefits, limitations, and potential risks of a virtual encounter, including:

    a. those related to privacy (e.g., potential for privacy breaches); and
    b. any clinical limitations to providing virtual care and the potential requirement for in-person follow-up.[11]

14. Physicians **must** obtain informed consent during the initial virtual encounter and each time the benefits, limitations, and potential risks change (e.g., if the virtual modality used changes, or if the nature of the care significantly changes).

CPSO Members Providing Virtual Care Across Borders[12]

15. When providing or assisting in the provision of virtual care to a patient in another province, territory, or country, physicians **must:**

    a. comply with the licensing requirements of that jurisdiction;[13] and
    b. ensure they have appropriate liability protection.[14]

[9] For more information on privacy and security safeguards see the *Advice to the Profession: Virtual Care* document.
[10] For the purposes of this policy, the telephone is considered secure technology.
[11] For more information about obtaining informed consent see the *Advice to the Profession: Virtual Care* document.
[12] CPSO maintains jurisdiction over its members regardless of where (i.e., physical location) or how (i.e., in-person or virtually) they practise medicine, and will investigate any complaints made about a member, regardless of whether the member or patient is physically located in Ontario.
[13] The medical regulatory authority of the jurisdiction where the physician and/or patient are physically located may also require that physicians hold an appropriate medical licence in that jurisdiction.
[14] Physicians can consult the Canadian Medical Protective Association (CMPA) and the Ministry of Health for more information on liability protection and billing in these circumstances.

Licensing Requirements when Providing Virtual Care to Ontario Patients

16. Physicians providing virtual care to Ontario patients located in Ontario[15] **must** hold a valid and active certificate of registration with the CPSO, unless the provision of virtual care from a physician licensed elsewhere is in the patient's best interest;[16] for example, the care sought is:

    a. not readily available in Ontario (e.g., specialty care);
    b. provided within an existing physician-patient relationship and intended to bridge a gap in care; or
    c. for urgent or emergency assessment or treatment of a patient.[17]

[15] For guidance related to treating Ontario patients who are temporarily out of the province, please see the *Advice to the Profession: Virtual Care* document.
[16] This provision does not permit physicians licensed in other jurisdictions to circumvent Ontario licensing requirements and primarily practise in Ontario. It is intended to allow the provision of limited virtual care by physicians licensed in other jurisdictions in circumstances where it will serve a patient's best interests.
[17] CPSO reserves the right to take action against physicians who are providing virtual care to Ontario patients in accordance with Provision #16 if they are not meeting the standard of practice. If CPSO becomes aware of concerns about virtual care provided to an Ontario patient by a physician who is not licensed in Ontario it may share that information with the regulatory authority that has jurisdiction over the member, so that appropriate action can be taken by that regulatory authority.

Advice to the Profession: Virtual Care

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.

Virtual care plays an important role in the health-care system by improving access to care and increasing efficiencies in the way it is delivered. As technology continues to evolve, it will bring new opportunities and advancements in the delivery of virtual care. At the same time, virtual care is not appropriate in every instance. Not all conditions can be treated virtually and not everyone has equal access to or is comfortable using technology.

CPSO's *Virtual Care* policy sets expectations for physicians about the appropriate use of virtual care. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the policy and provide guidance around how these expectations may be effectively discharged.

Virtual Care is the Practice of Medicine

Can you elaborate on the scope of the policy? What medical services are captured by the term "virtual care"?

Virtual care is defined in the policy as "any interaction between patients and/or members of their circle of care that occurs remotely, using any form of communication or information technology, including telephone, video conferencing, and digital messaging (e.g., secure messaging, emails, and text messaging), with the aim of facilitating or providing patient care."[1]

This means that virtual care includes *all* medical services to patients (e.g., assessing, diagnosing, giving advice, teleradiology, telemonitoring, etc.) as well as inter-professional and intra-professional consultations (i.e., remote consultations between providers).

The principles set out in the policy are broadly applicable to all medical services conducted virtually, including services such as independent medical exams (IMEs) which are not for the provision of health care but are conducted for the purpose of a

[1] This definition was adapted from Shaw, J., Jamieson, T., Agarwal, P., Griffin, B., Wong, I., & Bhatia, R.S. (2018). Virtual care policy recommendation for patient-centred primary care: findings of a consensus policy dialogue using a nominal group technique. *Journal of Telemedicine and Telecare, 24*(9), 608-615.

third party process.

If I have the competence to provide in-person care, do I have the competence to provide the same type of care virtually?

The provision of virtual care may require the use of new technology, as well as a modified approach to care that is distinct from in-person care and there may be a learning curve when you first begin to provide care virtually. For example, in the absence of seeing a patient in person, assessments done over the telephone or via videoconferencing might require you to ask additional or different questions than you would in person. As a result, some physicians might need additional training around the technical components of virtual care or time to adapt to the new approach to care. To ensure patient safety, the policy recognizes this distinct skillset and requires that physicians have the competence to provide care virtually.

The policy requires the standard of care to be maintained when providing virtual care. How can I meet the standard of care when delivering care virtually?

The standard of care remains the same whether you are providing in-person or virtual care. Meeting the standard of care in a virtual environment includes: continuing to obtain a relevant history, conducting appropriate examinations, ordering diagnostic tests, and making diagnoses and/or differential diagnoses, as appropriate. It involves continuing to explain the benefits and risks of treatment options, providing suitable treatment plans, and ensuring necessary follow-up. It also includes ensuring that patients referred to specialists are appropriately investigated and treated before a referral is made.

In most instances, if a physical examination is required in order to appropriately assess or treat the patient, then virtual care will not enable you to meet the standard of care in that instance. There are limited exceptions, however, such as during contagious disease outbreaks, or for a patient whose access might be otherwise limited to the point of risking patient harm. A risk-benefit analysis can help physicians determine whether the standard of care can be met with a virtual encounter.

Virtual Care and Patient Best Interest

Why doesn't the policy specify the circumstances where virtual care would or would not be appropriate?

Every patient's needs are unique, technology is continuously evolving, and a number of considerations will play into the type of care that is appropriate in each instance. Issues that might require in-person care today may be able to be treated virtually in the future. As a result, the policy recognizes that physicians will need to exercise professional judgment to make these determinations on a case-by-case basis.

Where can I find additional resources that can assist me in determining when virtual care is appropriate?

The *Virtual Care Playbook* is a resource developed by the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada that can assist physicians in determining when virtual care is appropriate and what conditions may be appropriately treated virtually. With virtual care becoming more prevalent, CPSO anticipates that additional clinical practice guidelines will be developed to help support physician decision-making.

My patient and I disagree about whether virtual care or in-person care is warranted. How can disagreements be addressed?

Not all patients have access to technology, are comfortable using technology, or are able to receive care virtually. At the same time, not all patients have equal ability to make themselves available for in-person care or have the same access to local in-person options. As always, you will need to consider what is in your patient's best interest and find a solution that satisfies the need for patient access, safety, and quality care, while prioritizing patient preference, where possible (i.e., where clinically appropriate and available).

Although physicians are ultimately responsible for determining which modality will result in the best outcome for patients, effective and sensitive communication in these instances can go a long way towards resolving disagreements, including explaining why the preferred modality is in the patient's best interest (e.g., the limits or benefits of virtual care.)

Is it appropriate to use a 'virtual-first' approach in all instances?

A blanket virtual-first approach (i.e., triaging every patient with an initial virtual appointment) is not recommended in the absence of direction from the government (e.g., in relation to pandemics/public health measures). Use of a blanket virtual-first approach can delay necessary care and negatively impact patient safety as well as the system as a whole. Certain conditions will require in-person care and consideration needs to be given to the purpose and nature of the appointment at the point of scheduling or triaging.

Can I exclusively provide virtual care to patients?

Generally, virtual care is not meant to replace but to complement in-person care as there are limits to what can be done virtually and there are some patients that cannot be appropriately treated virtually. The standard of care is often difficult to meet in a completely virtual environment. For example, an exclusively virtual comprehensive

primary care practice would not be able to meet the standard of care. Depending on the nature of the practice, meeting the standard of care will generally require physicians to provide some in-person care. A fully virtual practice might be possible in some limited circumstances (e.g., radiology, psychotherapy, etc.).

What are key expectations to be aware of when practising in a virtual walk-in clinic?

When practising virtually, you must continue to meet the same legal and professional obligations that apply to care that is provided in-person, including the expectations set out in other CPSO policies such as the *Walk-in Clinics*, *Medical Records Documentation*, and *Medical Records Management* policies.

Key expectations outlined in the *Walk-in Clinics* policy include:

- Determining whether it would be appropriate to sensitively remind patients about the benefits of seeing their primary care provider, if they have one, for care within their physician's scope of practice;
- Communicating any limitations related to the episodic nature of walk-in clinic care to patients, as well as appropriate next steps to patients seeking care or services that are not provided; and
- Providing the patient's primary care provider with a record of the encounter when the patient asks or when it is warranted from a patient safety perspective and consent has been obtained.

Key expectations related to medical record-keeping include:

- Having a written agreement that establishes custodianship and clear accountabilities regarding medical records, including enduring access for physicians and their patients (e.g., in the event you need to respond to a complaint or investigation); and
- Ensuring documentation is complete and comprehensive, containing:
    - all relevant information;
    - information that conveys the patient's health status and concerns;
    - 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
    - documentation that supports the treatment or procedure provided (i.e., rationale for the treatment or the procedure is evident in the record).

For additional guidance regarding virtual walk-in clinics see the Canadian Medical Protective Association's (CMPA) *Thinking of working with virtual clinics? Consider these medical-legal issues*.

Privacy, Security, and Informed Consent

Where can I find more information about how to comply with privacy and security obligations in a virtual environment?

The Information and Privacy Commissioner of Ontario has released comprehensive guidelines regarding *Privacy and security considerations for virtual health care visits* to assist health care providers in complying with their privacy and security obligations in a virtual environment. Key issues addressed in these guidelines include:

- Requirements to safeguard information, such as having an information security management framework with administrative, technical, and physical safeguards;
- Obligations related to electronic services providers and health information network providers;
- The importance of developing a virtual care policy and for providing privacy and security training for employees and agents (i.e., individuals working on behalf of physicians);
- The importance of conducting privacy impact assessments to identify and manage the privacy and information security risks associated with virtual care;
- The need for a privacy breach management protocol;
- Special considerations for various forms of virtual care (e.g., videoconferencing, emails, patient portals, etc.); and
- A reminder for physicians that the same record retention requirements apply to virtual interactions, and that patients continue to have the same access and correction rights when receiving virtual care as with in-person care.

Additional resources include:

- CMPA's *Protecting patient privacy when delivering care virtually,* and
- OntarioMD and the Ontario Medical Association's free online *Virtual Care Privacy and Security Training Module* designed to help ensure that physicians and their staff fully understand how to comply with privacy and security obligations in a virtual care environment.

When providing virtual care, am I allowed to use technology (e.g., platforms) that cannot guarantee privacy and security?

The policy recognizes that in some limited situations patients' best interests might be served by using technology that is less secure (e.g., unencrypted) and sets out considerations to help physicians determine when using less secure technology might be appropriate. It also requires that if doing so, physicians obtain and document express patient consent (i.e., verbal or written). Ultimately, less secure technology may be best suited for minor tasks, such as scheduling appointments and appointment reminders, or for exceptional situations in which the patient is unable to receive virtual care using secure (e.g., encrypted) technology and consents to proceed with the technology available.

Where can I find more information about virtual care platforms that are appropriate for clinical use?

To assist health care providers in selecting virtual care solutions appropriate for clinical use, Ontario Health has established a provincial standard and launched a verification process for virtual care solutions. For a list of verified virtual visit solutions (i.e., videoconferencing and secure messaging solutions that comply with provincial requirements), see their website.

What do I need to know about informed consent for the use of virtual care?

Consent includes informing patients about the benefits, risks, and limitations of virtual care (e.g., those related to privacy and any clinical limitations), providing an opportunity for patients to ask questions, and receiving agreement from the patient to proceed with the virtual encounter.

Consent can be *express* (either verbal or written) or *implied* (i.e., proceeding with the encounter after an overview of the benefits, risks, and limitations have been identified). The nature of the interaction and degree of sensitivity of the personal health information being shared during the virtual encounter are key considerations when determining whether express or implied consent would be required in each instance. The higher the degree of sensitivity, the more likely express consent will be necessary.

The other element of consent is documentation which can take the form of a signed consent form that captures the identified benefits, risks, and limitations of virtual care *or* written notes in the patient's (electronic) medical record that capture the discussion with the patient about the use of virtual care.

Although the policy *does* require documenting consent in circumstances where less secure technology is used to deliver virtual care, it does *not* require documentation of

consent for the use of virtual care in every instance. Documentation is recommended as a best practice, particularly where patients express concern or raise questions about receiving virtual care.

For more information on informed consent please see the CMPA's *Virtual care: What about consent?* and the CMA's *Virtual Care Playbook* which includes a sample disclosure to patients.

Can someone other than the physician obtain informed consent for the delivery of virtual care?

Yes. The policy requires ensuring that informed consent is obtained for the delivery of care using a virtual modality. This means that consent can be obtained prior to or during the virtual encounter and can be obtained by someone working on behalf of the physician. It is ultimately up to the physician to ensure this expectation has been met.

Practice Issues

Can I delegate controlled acts remotely?

Controlled acts can be delegated remotely provided that the standard of care is met and the *Delegation of Controlled Acts* policy is complied with.

What do I need to know when considering opioid prescriptions or treatment via virtual care?

In addition to the general expectations regarding prescribing, CPSO's *Prescribing Drugs* policy also contains expectations specific to prescriptions for narcotic and other controlled substances which must be complied with.

Opioids have a unique risk profile, including the potential for misuse, abuse, and diversion. When determining whether it is appropriate to prescribe opioids virtually, you need to consider whether you can appropriately assess and mitigate those risks in the absence of an in-person assessment.

Providing Virtual Care Across Borders

Am I allowed to provide virtual care to Ontario patients who are temporarily out of the province or country?

If the policy expectations can be met, CPSO permits Ontario physicians to treat Ontario patients who are temporarily located outside of Ontario or Canada, where required to support continuity of care, patient safety, or patient best interest (e.g., providing follow-up care, communicating test results, answering questions about medications, etc.).

However, many jurisdictions consider the care to occur where the patient is physically located, and physicians will also need to be aware of and comply with the licensing requirements of the jurisdiction where the patient is receiving virtual care.

There may be specific rules regarding liability protection and billing in these circumstances. Physicians with questions about liability protection and billing can contact the CMPA and the Ministry of Health respectively for more information.

Is it permissible for physicians licensed in Ontario to treat Ontario patients when the physician is temporarily located outside of Ontario or Canada?

It depends. Licensing requirements vary between jurisdictions. Providing virtual care that supports continuity of care, patient safety, or patient best interests to existing patients while the physician is temporarily out of the province is permissible from the CPSO's perspective when this is allowed by the jurisdiction where the physician is located at the time and the standard of care is met.

There may be specific rules regarding liability protection and billing in these circumstances and physicians with questions about liability protection and billing can contact the CMPA and the Ministry of Health for more information.

If I am licensed in another jurisdiction, am I required to hold a certificate of registration in Ontario when providing virtual care to a patient who is temporarily located in Ontario?

No. Physicians licensed in other jurisdictions are not required to hold a certificate of registration in Ontario when providing virtual care to patients who ordinarily reside in that jurisdiction but are temporarily located in Ontario (e.g., who are on vacation in Ontario).

Where can I learn more about the CMPA's approach to liability protection in scenarios requiring cross-border virtual care?

Information on the CMPA's approach to assisting members with matters related to (cross-border) virtual care can be found in their guidance document *Principles of assistance: Practising Telehealth.*

Council Motion

Motion Title	Virtual Care – Revised Policy for Final Approval
Date of Meeting	June 17, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Virtual Care", formerly titled "Telemedicine", (a copy of which forms Appendix " " to the minutes of this meeting) as a policy of the College.

Council Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	June 17, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clause 7(2)(b) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public

Council Briefing Note

June 2022

Topic:	Presidential Compensation – Proposed By-law Amendment
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	Ensures that Presidential compensation is appropriate and within role parameters
Main Contacts:	Nathalie Novak, Chief Transformation Officer Cameo Allan, Manager of Governance Marcia Cooper, Sr. Corporate Counsel and Privacy Officer
Attachment:	Appendix A: Proposed Amendments to Fees and Remuneration By-Law

Issue

- Council is provided with proposed amendments to the *Fees and Remuneration By-law* to reflect proposed changes to the Presidential compensation model.

Background

- Council voted to adopt changes proposed to the President's compensation model in December 2018. Those changes included:
    - Rescinding the differential per diem rates for the president and Vice President, instead offering a flat rate per half day to all Council and Committee members;
    - Continuing the practice of submitting claims for work performed for CPSO Committees at the standard member rate; and
    - Implementing an annual stipend, adjusted annually with the cost of living increase approved by Council, to cover some elements of the President's work.
- The current compensation model has been accompanied by a guidance document that helps to articulate what kinds of activities are currently included in the stipend, those that

are not, and that elaborates on the broad principles contained in the by-law. This document has not been updated since 2019.

Current Analysis

- In January 2022, the Executive Committee indicated a preference to move from the current model of compensation, to one with fewer exclusions. Subsequently, in February 2022, the Executive Committee indicated a preference for a fixed-amount that includes all Presidential work.

- In the view of the Executive Committee, the Presidential role accounts for approximately one to one and a half full days of work per week (0.2-0.3 Full Time Equivalent), but requires availability that is more reflective of on-call work. This means that a higher base rate would be more reflective of the required availability and workload.

- Staff undertook an analysis to support the proposed changes to the presidential compensation model to transition to a fix-amount all-inclusive presidential salary.

- Adopting a fixed-amount approach is expected to have the following impacts:

    - Removing the need for billing or time tracking promotes the greatest administrative ease;

    - Treating each President as “of equal value” to the organization; and,

    - Promoting easier budget planning and reliability for the President as to expected compensation.

- This stipend would include all Presidential work, including but not limited to:

    - All Council, Executive, and Governance Committee preparation and meetings (including agenda setting meetings);

    - External stakeholder meetings in the presidential role (for example, the Ontario Medical Association, MPP, and government meetings);

    - Meetings with the Registrar and other CPSO staff;

    - Any ad-hoc communications related to presidential activity or organizational work requiring presidential sign-off;

    - CPSO-led trainings related to Council, or to the Executive, Governance, or presidential role;

- Interviews or time spent with Council members; and
- Any other activities identified by the Executive Committee.

- The stipend *would not* include work resulting from membership on other Committees that are not typically part of the Presidential portfolio. For example, work performed on the Education Advisory Group and optional activities, including conferences, would be eligible for reimbursement at the hourly rate.

- The stipend would only apply to physician members of Council in the Presidential role (as per section 20(2) of the Fees and Remuneration By-law). Under legislation, the CPSO would not be able to apply this model to public members serving as President.

- Proposed by-law amendments regarding this presidential compensation model are set out in Appendix A.

- These by-law amendments do not need to be circulated to the profession before being enacted.

- In accordance with the Executive Committee's prior direction, the proposed changes are suggested to retroactively apply to the current 2021-2022 Presidential term.

Next Steps

- If approved, the new compensation model will be presented to the Finance and Audit Committee for operational implementation.

Question for Council

1. Does Council approve the proposed by-law amendments?

APPENDIX A

PROPOSED AMENDMENTS TO FEES AND REMUNERATION BY-LAW RE PRESIDENTAL COMPENSATION

COUNCIL AND COMMITTEE REMUNERATION

20. … (3) Except as provided in subsection (8), t~~T~~he amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour.

(8) For all ~~other~~ College business conducted by the president that is part of or related to the role of the president (for greater certainty, including but not limited to, external stakeholder meetings~~ outside the College and government relations meetings~~ coordinated by the College), subsection 20(3) does not apply and 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.

For College business conducted by the president that is not part of or related to the role of the president, including, without limitation:~~The amount payable to the president under subsection 20(3)(a)~~, ~~applies to the following College business~~:

(a) ~~Council meetings~~ attendance at and preparation for meetings of, and work resulting from, CPSO advisory or working groups or CPSO committees other than the Executive Committee, the Governance Committee and the Finance and Audit Committee; and~~,~~

(b) ~~meetings of committees which the president is required to attend~~ authorized optional activities such as conference attendance,

~~(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.~~

the amount payable to the president is as set out under subsection 20(3).

For greater certainty, subsection (4) applies to the president, and amounts payable under subsection (4) are not included in the stipend or in amounts payable to the president as set out in subsection 20(3).

Commented [MC1]: This presumes that the changes (by-law no 149) have been passed by Council first.

Commented [MC2]: Travel expenses provision

~~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.~~

Council Motion

Motion Title	Presidential Compensation
Date of Meeting	June 17, 2022

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. 150:

By-law No. 150

(1) Subsection 20(3) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

Council and Committee Remuneration

20. … (3) Except as provided in subsection (8), the amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour.

(2) Subsection 20(8) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

Council and Committee Remuneration

20. … (8) For all College business conducted by the president that is part of or related to the role of the president (for greater certainty, including but not limited to, external stakeholder meetings coordinated by the College), subsection 20(3) does not apply and 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.

For College business conducted by the president that is not part of or related to the role of the president, including, without limitation:

(a) attendance at and preparation for meetings of, and work resulting from, CPSO advisory or working groups or CPSO committees other than the Executive Committee, the Governance Committee and the Finance and Audit Committee; and

(b) authorized optional activities such as conference attendance,

the amount payable to the president is as set out under subsection 20(3).

For greater certainty, subsection (4) applies to the president, and amounts payable under subsection (4) are not included in the stipend or in amounts payable to the president as set out in subsection 20(3).

Council Briefing Note

June 2022

Topic:	*Social Media* – Revised Draft Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Setting clear expectations and guidance for physicians to support responsible and professional use of social media that upholds the reputation of the profession and maintains public trust
Main Contact:	Alex Wong, Policy Analyst
Attachments:	Appendix A: Revised Draft *Social Media* policy Appendix B: Revised Draft *Advice to the Profession: Social Media*

Issue

- The College's *Social Media – Appropriate Use by Physicians* statement ("Social Media statement" or "statement") is currently under review. A new draft *Social Media* policy was developed and released for external consultation in June to August 2021, along with a companion draft *Advice to the Profession* document ("*Advice*"). The draft policy and *Advice* have been revised in light of the feedback received through this engagement activity.

- Council is provided with an overview of the key issues considered by the Policy Review Working Group as well as the proposed revisions. Council is asked whether the draft policy can be approved as a policy of the College replacing the Social Media statement.

Background

- The current Social Media statement was approved by Council in 2013. At the time, social media was a newly emerging area of interest and the Executive Committee and Council preferred to take the approach of setting out general guidance in a statement rather than setting out specific expectations in a policy.

- As social media use among physicians has increased and as it presents new risks and challenges for physicians to navigate, a proposal to update this approach and replace the Social Media statement with a new *Social Media* policy setting out specific expectations for physicians' social media use has been brought forward for consideration.

- Following extensive research,[1] a preliminary consultation, and additional engagement with the Citizen Advisory Group[2], a new draft policy was developed based on direction from the Policy Review Working Group.[3]

- The draft policy was approved for external consultation by Council in June 2021. The accompanying *Advice* was also released at this time.

    - A total of 1014 responses were received: 101 through written feedback and 913 via the online survey.[4] The majority of responses received were from members of the public.

    - All of the consultation feedback received has been posted on a dedicated page of the College's website. An overview of the feedback received was provided to Council in the Policy Report at the September 2021 Council meeting.

- Overall, physician respondents generally agreed that they would benefit from a policy that sets out specific expectations around social media use. They were more likely than other respondents to show support for specific policy expectations.

    - In contrast, many members of the public who responded to the survey felt that regulation of physicians' conduct on social media would be an overreach and that the College has been censoring physicians expressing "minority views" about the COVID-19 pandemic, vaccines, and treatments.

- There was also general agreement with the principles of the draft policy, while concerns tended to relate to its potential interpretation and application. For instance, there were concerns about the use of subjective language (e.g., "others would perceive as"), the meaning of specific terms (e.g., "respectful" and "disparaging"), and certain examples of disruptive behaviour (e.g., "profane" language).

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[1] While statements are not typically reviewed in the same way as policies, given the evolution of this issue, a review of the statement was undertaken in accordance with the usual policy review process. This included a literature review; jurisdictional scan; a review of decisions from the Inquiries, Complaints, and Reports Committee (ICRC), the Discipline Committee, and the Health Professions Appeal and Review Board (HPARB); and review of inquiries and feedback from staff in Public Advisory Services (PAS).

[2] This survey involved 16 participants providing responses to hypothetical scenarios presented to get perspectives on what members of the public would find low risk or high risk and unprofessional or professional conduct by physicians on social media.

[3] The Working Group at the time was composed of Brenda Copps, Janet van Vlymen, Sarah Reid, Karen Saperson, Peter Pielsticker, and Lydia Miljan, and Medical Advisor Keith Hay. Additional support was provided by Saroo Sharda (Medical Advisor and Equity, Diversity, Inclusion Lead) and Sayran Sulevani (Legal Counsel), later replaced by Ruth Ainsworth (Legal Counsel).

[4] Organizational responses included: Canadian Medical Protective Association (CMPA); Chabad Waterloo; College of Dietitians of Ontario (CDO); Doctors Against Racism and Antisemitism (DARA); Information and Privacy Commissioner of Ontario (IPC); Ontario Homeopathic Medical Association (OHMA); Ontario Medical Association (OMA) Section on Plastic Surgery; and Professional Association of Residents of Ontario (PARO).

- Physician respondents also expressed a need for a clearer delineation between personal and professional use of social media.

Current Status and Analysis

- Revisions have been made to both the draft *Social Media* policy (**Appendix A**) and *Advice to the Profession* (**Appendix B**), predominantly in response to consultation feedback.

- While many of the revised draft policy expectations are largely consistent with those of the draft policy that was released for consultation, updates have been made to address the concerns raised by consultation respondents and to enhance clarity of the expectations.

- An overview of the key issues considered by the Policy Review Working Group along with corresponding revisions is set out below.

Key Revisions in Response to Feedback

Preamble

- Recognizing the challenges of regulating social media and the potential reach of a policy of this nature, the preamble was updated to more clearly articulate the purpose and intention of the policy. Specific language was added to recognize the need to balance a physician's freedom of expression and their professional responsibilities in the social media realm. Additionally, the preamble indicates that the policy's focus is on a physician's professional use of social media. but it can also apply to personal use depending on several factors, for example, the connection between the physician's conduct and their professional role.

Professionalism

- In response to feedback that was concerned that specific terms used as examples of unprofessional conduct lacked clarity and were subject to interpretation, the professionalism provisions were revised and condensed to adopt a more high-level and principle-based approach.

    - Specific unprofessional behaviours based in law (e.g., defamation, hate speech) were moved to the footnote identifying relevant legislative requirements.

    - Some examples of disruptive behaviour that were included in the previous draft of were removed to avoid the misconception that these would be considered disruptive behaviour in all instances, recognizing the context-specific nature of conduct and communication on social media.

- The concept of "disruptive behaviour" was retained as it has a well-established meaning in the regulatory and practice environment.[5] However, to address concerns raised regarding the use of the term "disruptive" because of its meaning in the context of advocacy, revisions were made to clarify the intended meaning. Specifically, a definition of disruptive behaviour[6] was added to the policy, with additional clarification to:

    - note that disruptive behaviour will most commonly be identified through a pattern of events, although it may sometimes be demonstrated through a single act; and

    - give examples of what disruptive behaviour may include (e.g., bullying, attacking, or harassing others and making discriminatory comments) and what it is likely not to include (e.g., constructive criticism offered in good faith with the intention of improving patient care or the health-care system).

- The *Advice* document has been updated to address the intersection between professional and personal social media use. Specifically, it explains that the policy's focus is on a physician's professional use but can apply to personal use depending on several factors (e.g., the nature and seriousness of the conduct itself, whether or not the physician was known to be, could reasonably be known to be, or represented themselves as a member of the profession, and the connection between the conduct and the physician's role and/or the profession.)

Other

- While the following provisions were broadly supported, revisions were made to further align expectations with relevant policy and legislation:

    - The provisions around sharing health-related information were updated to align more closely with the requirements found in the *Advertising* policy (i.e., including a prohibition against disseminating false information, in addition to the existing prohibitions against disseminating misleading or deceptive information.) Additional guidance was included in the *Advice* document regarding evaluating the strength of evidence and the potential risks of sharing health information online.

    - Based on feedback from the Information and Privacy Commissioner of Ontario and the Canadian Medical Protective Association, revisions were made to the provisions around seeking out patient health information online to align more closely with expectations in the *Personal Health Information Protection Act, 2004* around collection, use, and disclosure of personal health information.

[5] Including in the College's *Physician Behaviour in the Professional Environment* policy and *Guidebook for Managing Disruptive Physician Behaviour* developed by the College and the Ontario Hospital Association.
[6] Disruptive behaviour is defined in the policy as "inappropriate words, actions, or inactions by a physician that interfere with (or may interfere with) the physician's ability to collaborate, the delivery of quality health care, or the safety or perceived safety of others."

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Questions for Council

1. Does Council approve the revised draft *Social Media* policy as a policy of the College and rescind the *Social Media – Appropriate Use by Physicians* statement?

Social Media

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.

Additional information, general advice, and/or best practices can be found in companion resources, such as *Advice to the Profession* documents.

Definitions

Social media[1]**:** Online platforms, technologies, and practices that people use to share content, opinions, insights, experiences, and perspectives. Examples of social media include, but are not limited to, Twitter, Facebook, YouTube, Instagram, LinkedIn, and discussion forums.

Disruptive behaviour: Inappropriate words, actions, or inactions by a physician that interfere with (or may interfere with) the physician's ability to collaborate, the delivery of quality health care, or the safety or perceived safety of others. Disruptive behaviour may be demonstrated through a single act, but will more commonly be identified through a pattern of events. Disruptive behaviour may include, for example, bullying, attacking, or harassing others and making discriminatory comments.[2] An example of behaviour that is not likely to be considered disruptive behaviour includes constructive criticism offered in good faith with the intention of improving patient care or the health-care system.[3]

[1] For the purposes of this policy, the term "social media" may also refer to other electronic or digital communications such as email, websites, and text messaging, depending on the context in which it is used and its impact. For more information, see the *Advice to the Profession*.

[2] Discriminatory comments can take various forms, but may involve the expression of negative attitudes, stereotypes, and biases on the basis of protected grounds in the Ontario *Human Rights Code* (e.g., race, ethnic origin, creed, ancestry, colour, sexual orientation, gender identity, sex, disability, etc.) as well as other categories (e.g. socioeconomic status, education, weight, etc.).

[3] For more information on disruptive behaviour see the *Advice to the Profession*. The *Physician Behavior in the Professional Environment* policy and the *Guidebook for Managing Disruptive Physician Behaviour* contain further information on disruptive behaviour in the workplace environment.

Policy

This policy sets out expectations to help physicians navigate the online environment and prevent conduct that could harm the public's trust in individual physicians and the profession as a whole. The focus of this policy is on a physician's professional use of social media, but it can also apply to personal use depending on several factors, for example, the connection between the physician's conduct and their professional role.[4]

The College recognises that physicians have rights and freedoms under the *Canadian Charter of Rights and Freedoms*, including the freedom of expression, subject to reasonable limits. Physicians hold a respected position in society. Professional conduct and communication are important to preserve the reputation of the profession, foster a culture of respect, not adversely impact patient care, and avoid harm to the public while using social media.

1. Physicians **must** comply with the expectations set out in this policy, other College policies,[5] and other relevant legislative and regulatory requirements[6] when using social media.

Professionalism

2. Physicians **must** uphold the standards of medical professionalism, conduct themselves in a professional manner, and **not** engage in disruptive behaviour while using social media.

3. Physicians **must** consider the potential impact of their conduct on the reputation of the profession and the public trust.

4. Advocacy for patients and for an improved health care system is an important component of the physician's role. While advocacy may sometimes lead to disagreement or conflict with others, physicians **must** continue to conduct themselves in a professional manner while using social media for advocacy.

[4] For more information, see the *Advice to the Profession*.
[5] Including *Advertising*, *Boundary Violations*, *Physician Behaviour in the Professional Environment*, *Professional Obligations and Human Rights*, *Protecting Personal Health Information*, *Virtual Care*, and *Physicians' Relationships With Industry: Practice, Education and Research*.
[6] Including the *Personal Health Information Protection Act, 2004*, S.O. 2004, the *Medicine Act, 1991*, the *Libel and Slander Act,* R.S.O. 1990, the *Copyright Act*, and the *Criminal Code* (e.g., hatred offences under sections 318 – 320.1), and their regulations.

Health-related information and clinical advice

5. When disseminating general health information on social media for educational or information-sharing purposes, physicians **must:**
    a. disseminate information that is:
        i. verifiable and supported by available evidence and science, if making statistical, scientific, or clinical claims; and
        ii. **not** false, misleading, or deceptive.
    b. be aware of and transparent about the limits of their knowledge and expertise; and
    c. **not** misrepresent their qualifications.

6. When disseminating information on social media, physicians **must** be mindful of the risks of creating a physician-patient relationship or creating the reasonable perception that a physician-patient relationship exists.[7]
    a. Physicians **must not** provide specific clinical advice to others on social media unless they are able and willing to meet the professional obligations that apply to a physician-patient relationship and the requirements in the *Virtual Care* policy and the *Personal Health Information Protection Act, 2004* (*PHIPA*).[8]

Professional Relationships and Boundaries

7. Physicians **must** maintain professional and respectful relationships and boundaries with patients, persons closely associated with patients, and medical students and/or postgraduate trainees over whom they have responsibilities while using social media.[9]

8. While using social media, physicians **must** consider the impact on and **must not** exploit the power imbalance inherent in:
    a. the physician-patient relationship when engaging with a patient or persons closely associated with them; and

[7] For example, by providing information in a manner that would lead a reasonable person to rely on it as clinical advice. If asked a medical question, physicians can direct individuals to the appropriate channels to obtain care. See the *Advice to the Profession* for more information.
[8] The provision of clinical advice through information and communication technologies is considered providing virtual care. Physicians must continue to meet the standard of care, which can include performing a comprehensive assessment, considering risks and benefits of treatment options, obtaining consent, etc.
[9] Boundaries can be sexual, financial/business, social, or other. For the definition of a "patient", see the *Boundary Violations* policy. For more information on maintaining appropriate boundaries, see the *Advice*.

b. any relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating a medical student and/or trainee.[10]

Privacy and Confidentiality

9. Physicians **must** comply with the requirements set out in *PHIPA* and its regulations and the expectations set out in the College's *Protecting Personal Health Information* policy while using social media.

Posting patient health information

10. If a physician is posting original content on social media containing health information about a patient, physicians **must**:
    a. de-identify the patient information;[11] and/or
    b. obtain and document express and valid consent from the patient or substitute decision-maker (SDM) for the publication of the content on social media, including when there is any doubt that the anonymity of a patient can be maintained.[12]

11. In fulfilling the requirement to obtain express and valid consent from the patient or SDM, physicians **must**:
    a. show them the content to be published;
    b. inform them that consent to publication can be withdrawn at any point;
    c. inform them about the risks of publication of the content (for example, that once posted on social media it may be unable to be completely withdrawn);
    d. engage in a dialogue with them about the publication of the content, such as the purposes of posting the content, where it will be posted, and any other relevant information, regardless of whether supporting documents (such as consent forms, patient education materials or pamphlets) are used; and
    e. consider how the power imbalance inherent in the physician-patient relationship could cause patients to feel pressured to consent and take

[10] For more information on professional relationships with students and trainees, see the *Professional Responsibilities in Medical Education* policy.
[11] A privacy breach can occur if the sum of the information available is sufficient for the patient to be identified, even if only by themselves. For more information on de-identification see the *Advice to the Profession*.
[12] If relying on consent, physicians must only post a patient's personal health information, to the best of their knowledge, for a lawful purpose (in accordance with s.29(a) of *PHIPA*). For content posted for the purposes of advertising, physicians must comply with the General Regulation under the *Medicine Act, 1991*, S.O. 1991 and the *Advertising* policy.

reasonable steps to mitigate this potential effect (for example, by informing the patient that if they do not consent, it will not impact their care).

Seeking out patient health information

12. Physicians **must** refrain from seeking out a patient's health information online[13] without a patient's consent unless:
    a. the information is necessary for providing health care;
    b. there is an appropriate clinical rationale related to safety concerns;[14]
    c. the information cannot be obtained from the patient and relied on as accurate and complete, or cannot be obtained from the patient in a timely manner;
    d. they have considered whether it is appropriate to ask the patient for consent to seek out the information online; and
    e. they have considered how the search may impact the physician-patient relationship (for example, whether it would lead to a breakdown in trust).

13. Physicians **must** document the rationale for conducting the search, the limitations (if any) on the accuracy, completeness or up-to-date character of the information, and any other relevant information (for example, search findings and the nature of search) in the patient's record.

14. Physicians relying on patient health information found online for clinical decision-making **must**:
    a. take reasonable steps to confirm the information is accurate, complete, and up-to-date, as is necessary for its purposes, prior to using the information; and
    b. if it is safe and appropriate to do so, disclose to the patient the source of the information, the clinical rationale for obtaining the information, and any other relevant information.

[13] This excludes authorized use of electronic health tools, such as patient databases, for the delivery of health care.
[14] For more information on what may be considered a clinical rationale related to safety concerns, see the *Advice to the Profession*.

Advice to the Profession: Social Media

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.

Many physicians use social media to interact with others, share content with a broad audience, and seek out medical information online. Social media can present important opportunities to enhance education and facilitate discourse and knowledge translation. The use of social media, which is highly accessible, informal, fast-paced, and constantly evolving, raises questions about how physicians can uphold their professional obligations. This companion *Advice* document provides further guidance around how the expectations in the *Social Media* policy can be met.

General

Do these professional expectations apply to my personal use of social media?

The focus of the policy is on a physician's professional use of social media, but it can also apply to personal use. Several factors impact whether personal use of social media may be considered unprofessional, including, but not limited to, the nature and seriousness of the conduct and/or communication itself, whether or not the physician was known to be, could reasonably be known to be, or represented themselves as a member of the profession, and the connection between the conduct and/or communication and the physician's role and/or the profession.

Physicians may decide to use professional and personal accounts, but it is important to keep in mind that the professional and personal are not always easily separated. Even when posting in a personal capacity, others may know of your status as a physician, or physicians may sometimes share personal details on professional accounts. As such, it is important that physicians act professionally in both contexts.

Does the policy apply to other forms of electronic communications such as emails, text messaging, video conferencing, and messaging applications?

Depending on the purposes and contexts for which they are used, electronic communications that are not traditionally considered social media can have a broad impact and involve interaction with others in a manner similar to that of social media. In these circumstances, the policy is more likely to be applicable to a physician's conduct. For instance, responding to an email list or sending out an email newsletter can reach a

wide network of people online, similar to posting on a discussion forum or a group page on a social media platform.

Professionalism

What is considered disruptive behaviour?

Although the term "disruptive" may have different meanings in other contexts, in this policy disruptive behaviour is demonstrated when inappropriate conduct interferes with, or has the potential to interfere with, quality health care delivery, the physician's ability to collaborate, or the safety or perceived safety of others.

Disruptive behaviour poses a threat to patients and outcomes by inhibiting the collegiality and collaboration essential to teamwork, impeding communication, undermining morale, and inhibiting compliance with and implementation of new practices. Whether behaviour is truly disruptive depends on its nature, the context in which it arises, and the consequences flowing from it. Some examples which are not likely to be considered disruptive behaviour include constructive criticism offered in good faith with the intention of improving patient care or facilities or good faith patient advocacy.

What does the CPSO mean by "professionalism" and "reputation of the profession" when using social media?

Professionalism is a fluid and contextual concept. It can require physicians to navigate and balance their duties towards individual patients, the public, the health care system, colleagues, and themselves. CPSO's commitment to integrating equity, diversity, and inclusion is also relevant to how we may conceptualize professionalism, given that traditional concepts of professionalism have often centred around the identities and cultural norms of dominant groups.

In general, what is considered professional behaviour will be informed and guided by College resources, including policies, and other professional resources, such as the Canadian Medical Association's Code of Ethics and Professionalism and the Royal College of Physicians and Surgeons of Canada's CanMEDS Framework.

Maintaining trust is an important aspect of medical professionalism. Physician conduct can impact the reputation of the profession when it undermines public trust and confidence in the profession. This in turn can adversely impact patient access to health care and patient care itself. The evaluation of the potential impact of a physician's conduct and/or communication on the reputation of the profession will be based on an analysis of the facts and circumstances. In addition to communicating in accordance

with the tenets of professionalism as outlined above, upholding the reputation of the profession includes:

- acting in accordance with the law
- participating in professional regulation
- adhering to clinical standards and demonstrating professional competence
- maintaining the same standard of professional conduct in an online environment as expected elsewhere

What do I have to consider when engaging in health advocacy on social media?

CPSO, as well as the Royal College of Physicians and Surgeons of Canada's CanMEDS framework, recognizes that advocacy is a key component of a physician's role.

If you practise in an institutional setting, you may be subject to their policies or guidelines around social media use. Some institutions may require express permission before engaging in advocacy activities on social media that could be interpreted as directly involving them. You may also wish to consider whether it is appropriate to notify your institution's administration and/or members of the care team prior to engaging in advocacy online, even if no policies or guidelines require it.

On occasion, while engaged in advocacy intended for the betterment of patients, an institution, or the health-care system, physicians may find themselves in conflict with others, including colleagues or the administration of the institution where they work. In such cases, it may be necessary to consider the impact of the physician's conduct on their ability to deliver quality health care, their ability to collaborate, or the safety of others. When these are impaired by a physician's advocacy, it is important to consider whether the advocacy efforts are in fact in the best interests of patients and the public.

The College recognizes that, unfortunately, physicians may find themselves experiencing personal attacks or harassment online with respect to their advocacy. Physicians can familiarize themselves with and use privacy controls and reporting mechanisms to help address this conduct. The College also recognizes that these interactions can be harmful and distressing to physicians. A list of health and wellness resources for physicians can be found on the CPSO's website.

How can I support equity, diversity, and inclusion goals through my social media use?

There is a growing commitment to integrating cultural humility and cultural safety within the health-care system and the medical profession. Cultural humility is a perspective that involves exercising self-reflection and acknowledging oneself as a learner when it comes to understanding another's experience. Cultural safety is an

outcome that recognizes and strives to address power imbalances inherent in the health care system. The goal is an environment free of racism and other forms of discrimination, where people feel safe when receiving and accessing health care, and where providers feel safe and respected providing health care.

With these goals in mind, CPSO supports physicians striving to foster an environment that is inclusive. It is also important for physicians to be aware that their conduct on social media (including liking, sharing, or commenting on other content) may be visible to others and that unprofessional comments and behaviour (which can be overt, or more subtle, like microaggressions) have the potential to make others feel marginalized and impact their feelings of safety and trust, and potentially impact patients' willingness to access care. For more information, please visit CMPA's guidance related to cultural safety and CPSO's Equity, Diversity, and Inclusion resources.

What do I do if an individual reaches out to me on social media with a medical question?

Physicians are permitted to share health information that is intended for general education and not patient-specific. For example, information on a physician's blog on diabetic self-care or information on a business page that encourages patients to get a seasonal flu shot are not intended as a substitute for a physician's clinical advice. Clinical advice refers to individualized advice given to a specific patient for a particular health concern.

You can respond to questions without providing clinical advice. For instance, you can inform the individual that you do not provide advice on social media and direct them to make an appointment through appropriate channels, or you can provide information for emergency or urgent care services, if applicable.

Physicians interacting with patients online must meet privacy and confidentiality obligations, as outlined in the *Protecting Personal Health Information* policy. Physicians who provide clinical advice to patients online must comply with the *Virtual Care* policy and other relevant College policies.

What should I consider when sharing general health information that involves statistical, scientific, or clinical claims?

The policy requires that physicians disseminate information that is verifiable and supported by available evidence and science if making statistical, scientific, or clinical claims. It is important for physicians to also consider the potential associated risks of sharing such information.

When physicians share information online, it is likely to be given significant weight or value by many, especially when that information makes statistical, scientific, or clinical claims. Sharing information without strong scientific evidence can introduce risks, including that patients and members of the public will act on this information in a way that could jeopardize their health.

For instance, if a physician shares information about a potential new or unconventional drug or treatment, the risks of sharing this could include influencing members of the public to seek that drug when it may be inappropriate for them and when it may have unexpected negative consequences (e.g., side-effects). As when making treatment decisions for patients, generally speaking, the higher the potential risk, the higher the level of evidence required.

Keeping in mind the relationship between risks associated with specific claims and the strength of evidence appropriate to support those claims, the *Advice to the Profession: Complementary and Alternative Medicine* document may be informative. It provides additional information regarding how to evaluate the strength of evidence and various factors to consider.

What kind of information would be considered misleading or deceptive?

Sharing false information would be a breach of the expectations in the policy. What is considered "misleading or deceptive" is broader than this. Physicians can avoid being misleading or deceptive by thinking carefully about whether the wording of posts includes content that may lead the reader to an incorrect conclusion, create a false impression, or that leaves out key information or context.

In some circumstances, such as during a public health crisis, information may change and evolve rapidly, and information that may have been shared at one time that may subsequently be inaccurate or no longer applicable. The policy is not intended to capture such instances where physicians share what was the best available information at the time.

The policy is also not intended to prevent reasonable debate and/or exploration of new developments in medicine. However, physicians who make statements that contradict scientific consensus, including in the context of a public health crisis, can create confusion, increase mistrust, and impact overall public health and safety. As a physician, it is important to keep in mind that your statements, particularly those containing statistical, scientific, or clinical claims, can be very influential and be perceived as more credible, regardless of whether you are speaking about an issue within your expertise or not.

Professional Relationships and Boundaries

How can I maintain appropriate boundaries with patients on social media?

As a physician, there is an increased risk associated with managing a dual relationship with a patient, including the potential for compromised professional judgment and/or unreasonable patient expectations. Personal information is more readily accessible on social media and connecting online can lead to inappropriate self-disclosure by patients and/or physicians.

The College recognizes that, especially in smaller communities, physicians and patients may interact within the same social network. What entails maintaining appropriate boundaries may therefore differ depending on the circumstances. Maintaining appropriate boundaries may mean refraining from connecting with patients and persons closely associated with them on social media. Patients may feel pressured into accepting an invitation from their physician due to the inherent power imbalance in the physician-patient relationship. If a patient or a person closely associated with them requests to connect on social media, you must consider the potential impact on the physician-patient relationship. Relevant factors include the type of clinical care provided, the length and intensity of the relationship, and the vulnerability of the patient. When declining an invitation, you can discuss with the patient the reasons for doing so to prevent harm to the physician-patient relationship. Since personal content is generally limited on a professional social media account, using one can also help you connect with patients without compromising the therapeutic relationship.

Physicians must also comply with the expectations in the *Boundary Violations* policy when engaging with patients and persons closely associated with them.

Privacy and Confidentiality

How do I de-identify information if I want to post about a patient on social media?

To de-identify the personal health information of an individual means to remove any circumstances that it could be utilized, either alone or with other information, to identify the individual.

An unnamed patient may still be identified through a range of information, such as a description of their clinical condition, or date, time, and/or location. When posting photographs, even if a patient is not directly pictured, other details such as the timestamp or location (which may be found in a photograph's metadata), can be used to reveal information about an individual. Even if only the patient can identify themselves from the information, that may be deemed a breach of confidentiality.

Given the increased risks of identification and the highly accessible and permanent nature of the internet, protection of patient privacy is paramount and physicians may wish to consider obtaining consent for posting even de-identified information whenever possible. Physicians must obtain and document consent before publishing patient information where there is any doubt that the patient can be kept anonymous (for example, posting a photograph with an identifiable part of a patient's body).

Why must I refrain from seeking out patient health information if it is publicly available?

The policy aligns with the requirements in the *Personal Health Information Protection Act, 2004* (PHIPA), which only permits indirect collection of personal health information without consent in limited circumstances. In addition, physicians preserve patient trust and protect the physician-patient relationship by refraining from seeking out patient health information online without consent. Many patients hold a reasonable expectation of privacy that their physicians will not search for their information online. Patients may perceive this to be a boundary violation, a lack of trust, or a lack of respect for their autonomy, which may lead to a breakdown in the physician-patient relationship.

What are appropriate clinical rationales related to safety concerns for seeking out patient health information online?

Situations where there is a risk of serious bodily harm to a patient or to others and danger is imminent would most clearly establish an appropriate clinical rationale related to safety concerns, for instance, where there are concerns about the risk of suicide or serious harm to a patient. There are also circumstances which, in the physician's professional judgment, may include urgent or emergent factors and it may be reasonable to search for information about them online in order to deliver appropriate care to the patient. For instance, this may occur when a patient presents to the emergency room unresponsive or otherwise unable to provide critical information.

What can I do to protect my privacy while using social media?

It is important to keep in mind that privacy can never be fully guaranteed online, even when posting in a closed forum. Posts can be shared more widely than originally intended (for example, screenshots of posts and messages can be shared on other platforms) and can be hard to remove once online. Resources from the Office of the Privacy Commissioner of Canada below provide useful guidance on how physicians can customize account privacy settings to better maintain control over and limit access to their personal information when posting online.

Resources

Canadian Medical Protective Association

Social media: The opportunities, the realities
Top 10 tips for using social media in professional practice
Good Practice Guide: Social Media
Using electronic communications, protecting privacy
Participating in health advocacy
Advocacy for change: An important role to undertake with care

Office of the Privacy Commissioner of Canada

Staying safe on social media
Privacy and social media in the workplace
Tips for using privacy settings

Office of the Information and Privacy Commissioner of Ontario

De-identification Centre
Privacy and Security Considerations for Virtual Health Care Visits
Frequently Asked Questions: Personal Health Information Protection Act

Council Motion

Motion Title	*Social Media* - Revised Policy for Final Approval
Date of Meeting	June 17, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the policy “Social Media” (a copy of which forms Appendix “ “ to the minutes of this meeting) as a policy of the College, and rescinds the statement “Social Media – Appropriate Use by Physicians”, (a copy of which forms Appendix “ “ to the minutes of this meeting).