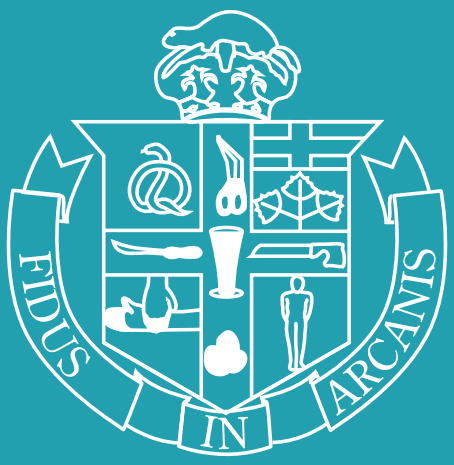
The College of Physicians and Surgeons of Ontario

Meeting of Council



FEBRUARY 24, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Friday February 24, 2017 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m. on Friday February 24, 2017

Rocco Gerace, MD
Registrar

January 23, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
February 24, 2017
Council Chamber, 3rd Floor, 80 College Street, Toronto

CALL TO ORDER

9:00 President's Announcements

9:05 Council Meeting Minutes of December 1 and 2, 2016 ……..1/5
Minutes of Special Meeting of Council of December 16, 2016…….....17

Executive Committee Report to Council ……...20

9:10 Uninsured Services: Billing and Block Fees – Draft for Consultation.....22

The College's Block Fees and Uninsured Services policy is currently under review. Council is provided with an overview of the policy review process undertaken to-date, as well as a copy of the new draft policy, entitled Uninsured Services: Billing and Block Fees. Council is asked whether the draft policy can be released for external consultation.

For Decision

9:30 Governance Committee Report……...38

An election will be held to fill Public Member Vacancy on 2017 Governance Committee

For Decision

9:45 College Oversight of Fertility Services – Consultation Report and Revised Draft Regulations…….....44

Council is provided with a report on the consultation and proposed revisions made to Ontario Regulation 114/94, Part XI that would allow the College to enter and inspect premises where fertility services are performed. Council is asked whether the revised draft regulation can be approved for submission to government.

For Decision

10:00 Proposed Fee Increases – Consultation Report……..56

At the annual budget meeting of the Finance Committee on October 11, 2016, the Finance Committee recommended to Council several fee increases related to Applications, Certificates of Professional Conduct and Incorporation. Proposed changes to the Applications and Certificates of Professional Conduct fees required circulation to the membership. The Finance Committee has determined that these increases are necessary to meet the growing demands of the College. Council is asked to approve the by-law.

For Decision

10:15 ***Refreshment Break***

PRESENTATION

10:30 Practice Ready Assessment (PRA)……59

Sten Ardel, Chief Executive Officer, Touchstone Institute

The Ministry of Health and Long Term Care has requested the creation of a PRA program for family medicine to launch as a pilot in 2017. The program, which aligns with national standards, is designed to assess and identify International Medical Graduates (IMG's) who are deemed practice ready. Mr. Ardel will provide an overview of the program.

The Registration Committee and Executive Committee recommend formalizing a policy permitting the registration of approved candidates. Council is asked to approve this recommendation.

For Discussion and Decision

COUNCIL AWARD PRESENTATION

11:30 Council Award Winner: Dr. Shazia Ambreen of Alliston, Ontario……80

12:00 ***LUNCH***

1:00 IN CAMERA

1:30 Bill 87, Protecting Patients Act Pg i - xvi

Bill 87, the Protecting Patients Act was introduced in December 2016. Council will be provided with an overview and analysis of the Bill along with possible implications for the College. Council is asked to approve a proposed general response to the Bill.

For Decision

2:00 Opioid Update and Guidelines Consultation.....81

The briefing note summarizes recent developments and the current status of on-going opioid work at the CPSO. In addition, it provides an overview of the recently released draft recommendations for Use of Opioids in Chronic Non-Cancer Pain from the Michael G. DeGroote National Pain Centre at McMaster University.

For Discussion

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REGISTRAR'S REPORT

Strategic Reporting – Dashboard

94

MEMBER TOPICS

INFORMATION ITEMS

1. Renewal of Third Pathway Status – Medical Psychotherapy Association Canada (MDPAC) (Formerly General Practice Psychotherapy Association (GPPA).....**95**
2. Policy Report.....**187**
3. Medical Assistance In Dying Update.....**209**

INFORMATION ITEMS

2:30 IN CAMERA

3:30 ADJOURNMENT

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Council Meeting Minutes of December 1 and 2, 2016**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The Council accepts as correct the minutes of the meeting of the Council held on December 1 and 2, 2016.

- OR -

The Council accepts the minutes of the meeting of the Council held on December 1 and 2, 2016 with the following corrections:

1.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Special Council Teleconference Meeting Minutes of December 16, 2016**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The Council accepts as correct the minutes of the meeting of the Special Council Teleconference meeting held on December 16, 2016.

- OR -

The Council accepts the minutes of the meeting of the Special Council Teleconference meeting held on December 16, 2016 with the following corrections:

1.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Uninsured Services: Billing and Block Fees - Draft Policy for Consultation**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The College engage in the consultation process in respect of the draft policy “Uninsured Services: Billing and Block Fees” (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Governance Committee Election**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The Council appoints _____ to the Governance Committee for 2017.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Practice Ready Assessment In Ontario (PRA)**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The Council approve the recommendation of the Registration Committee and the Executive Committee that participants in the Practice Ready Assessment program (PRA) be issued the Pre-entry Assessment Period (PEAP) Certificate of Registration for the PRA period and a subsequent restricted certificate of practice under supervision for twenty four months**.**

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **College Oversight of Fertility Services – Regulation Change**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The Council approve and formally submit a regulation amendment proposal to the Ministry of Health and Long-Term Care with the following amendments to Ontario Regulation 114/94 ("O.Reg. 114/94") made under the *Medicine Act, 1991*:

1. **That Subsection 44(1) of O.Reg. 114/94 be amended by adding 44(1)(b.1), 44(1)(e) and 44(3), as highlighted below:**

44. (1) In this Part,

"inspector" means a person designated by the College to carry out an inspection under this Part on behalf of the College;

"premises" means any place where a member performs or may perform a procedure on a patient but does not include a health care facility governed by or funded under any of the following Acts:

1. The *Long-Term Care Homes Act, 2007*.
2. The *Developmental Services Act*.
3. The *Homes for Special Care Act*.
4. Revoked: O. Reg. 134/10, s. 1 (2).
5. Revoked: O. Reg. 192/14, s. 1.
6. The *Ministry of Community and Social Services Act*.
7. The *Ministry of Correctional Services Act*.
8. The *Ministry of Health and Long-Term Care Act*.
9. Revoked: O. Reg. 134/10, s. 1 (2).
10. The *Private Hospitals Act*.
11. The *Public Hospitals Act*;

"procedure" means,

(a) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed under the administration of,

(i) general anaesthesia,

(ii) parenteral sedation, or

(iii) regional anaesthesia, except for a digital nerve block, and

(b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to,

(i) any tumescent procedure involving the administration of dilute, local anaesthetic,

(ii) surgical alteration or excision of any lesions or tissue performed for cosmetic purposes,

(iii) injection or insertion of any permanent filler, autologous tissue, synthetic device, materials or substances for cosmetic purposes,

(iv) a nerve block solely for the treatment or management of chronic pain, or

(v) any act that, in the opinion of the College, is similar in nature to those set out in subclauses (i) to (iii) and that is performed for a cosmetic purpose,

(b.1) any act that is performed in connection with,

(i) in vitro fertilization,

(ii) artificial insemination, or

(iii) sperm cryopreservation or oocyte cryopreservation,

but does not include,

(c) surgical alteration or excision of lesions or tissue for a clinical purpose, including for the purpose of examination, treatment or diagnosis of disease, ~~or~~

(d) minor dermatological procedures including without being limited to, the removal of skin tags, benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangioma and neurofibromata, or O. Reg. 134/10, s. 1 (1, 2); O. Reg. 192/14, s. 1.

(e) the sole act of counseling or referral for the procedures set out in subsection (b.1).

(2) Anything that may be done by the College under this Part may be done by the Council or by a committee established under clause 94 (1) (i) of the Health Professions Procedural Code. O. Reg. 134/10, s. 1 (1).

(3) For the purposes of procedures included in subsection 44(1)(b.1) the definition of “premises” shall include a health care facility governed by or funded under The *Public Hospitals Act*.

2. That Subsection 47(c) of O.Reg. 114/94 be amended by adding the words highlighted below:

47. It is the duty of every member whose premises are subject to an inspection to,

(a) submit to an inspection of the premises where he or she performs or may perform a procedure on a patient in accordance with this Part;

(b) promptly answer a question or comply with a requirement of the inspector that is relevant to an inspection under this Part; and

(c) co-operate fully with the College and the inspector who is conducting an inspection of a premises, including collection and provision of information requested, in accordance with this Part. O. Reg. 134/10, s. 1 (1).

3. That Section 49 of O.Reg. 114/94 be amended by adding Subsection 49(6), as highlighted below:

49. (1) No member shall commence using premises for the purposes of performing procedures unless the member has previously given notice in writing to the College in accordance with subsection (5) of the member's intention to do so and the premises pass an inspection or pass an inspection with conditions. O. Reg. 134/10, s. 1 (1).

(2) The College shall ensure that an inspection of the premises of a member referred to in subsection (1) is performed within 180 days from the day the College receives the member's notice. O. Reg. 134/10, s. 1 (1).

(3) A member whose practice includes the performance of a procedure on a patient in any premises on the day this Part comes into force shall give a notice in writing to the College in accordance with subsection (5) within 60 days from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(4) The College shall ensure that an inspection of the premises of a member referred to in subsection (3) is performed within 24 months from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(5) The notice required in subsections (1) and (3) shall include the following information, submitted in the form and manner required by the College:

1. The full name of the member giving the notice and the full name of the owner or occupier of the premises, if he or she is not the member who is required to give notice under this section.
2. The full name of any other member who is practising or may practise in the premises with the member giving the notice.
3. The name of any health profession corporation that is practising at the premises.
4. The full name of any hospital where the member or other members at the premises have privileges or where arrangements have been made to handle emergency situations involving patients.
5. The full name of any other regulated health professional who is practising or may practise in the premises with a member at the premises, along with the name of the College where the regulated health professional is a member.
6. The full address of the premises.
7. The date when the member first performed a procedure on a patient in the premises or the proposed date when the member or another member intends to perform a procedure on a patient at the premises.
8. A description of all procedures that are or may be performed by a member or other members at the premises and of procedures that may be delegated by the member or other members at the premises.
9. A description of any equipment or materials to be used in the performance of the procedures.
10. The full name of the individual or corporation who is the owner or occupier of the premises, if different from the member giving the notice.
11. Any other information the College requires that is relevant to an inspection conducted at the premises in accordance with this Part. O. Reg. 134/10, s. 1 (1).

49(6) All timelines and notice requirements provided in this section apply to every premises where a member performs or may perform a procedure listed in subsection 44(1)(b.1) with reference to the day that section 44(1)(b.1) comes into force.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **2017 Annual Fee**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 111:

By-law No. 111

Subsection 4(a) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted:

Annual Fees

4. Annual fees for the year beginning June 1, 2017, are as follows:

(a) **$1625 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;**

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **2017 Application Fees Increase**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 113,

By-law No. 113

1. Subsections 1(a) and (d) of By-Law No. 2 (the Fees and Remuneration By-law) are revoked and the following are substituted:

APPLICATION FEES

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

2. Section 1 of By-Law No. 2 (the Fees and Remuneration By-law) is amended by deleting the "." at the end of subsection 1(g), substituting it with a ";", and adding the following as new subsection 1(h):

APPLICATION FEES

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b) or (d).

3. Section 16 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and the following is substituted:

16. There is a $75 fee for the College to issue a certificate of professional conduct for a member.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

The Council 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.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **February 24, 2017**

It is moved by_____,

and seconded by_____, that:

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.

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO DECEMBER 1, 2016

Attendees:

Dr. Joel Kirsh (President)
Dr. El-Tantawy Attia (PhD)
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Ms. Diane Doherty
Mr. Harry Erlichman
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Major Abdul Khalifa
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Mr. Ron Pratt
Dr. John Rapin
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Eric Stanton
Dr. Peter Tadros
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watters

Non-voting Academic Representatives on Council: Dr. Akbar Panju and Dr. Robert (Bob) Smith

Regrets: Dr. John Jeffrey, Dr. Richard (Rick) Mackenzie, Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

Dr. Joel Kirsh called the meeting to order at 9 a.m., and welcomed members of Council and guests.

Council Meeting Minutes of September 8 and 9, 2016

01-C-12-2016

It is moved by Mr. Emile Therien and seconded by Mr. Sudershen Beri that:

The Council accepts the minutes of the meeting of the Council held on September 8 and 9, 2016.

CARRIED

Executive Committee's Report to Council – April to June 2016

Received with no comments.

FOR DECISION

Accepting New Patients Policy – Draft for Consultation

02-C-12-2016

It is moved by Dr. Marc Gabel and seconded by Mr. Ron Pratt that:

The College engage in the consultation process in respect of the draft policy "Accepting New Patients" (a copy of which forms Appendix "A" to the minutes of this meeting).

CARRIED

Ending the Physician-Patient Relationship Policy – Draft for Consultation
03-C-12-2016

It is moved by Dr. Eric Stanton and seconded by Dr. Barbara Lent that:
The College engage in the consultation process in respect of the draft policy "Ending the Physician-Patient Relationship" (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

Marijuana for Medical Purposes Policy Update

04-C-12-2016

It is moved by Dr. Marc Gabel and seconded by Dr. Jerry Rosenblum that:

The Council approves the revised policy "Marijuana for Medical Purposes", (a copy of which forms Appendix "C " to the minutes of this meeting) as a policy of the College.

CARRIED

PRESENTATION

Cynthia (Cindy) Morton, Chief Executive Officer, eHealth Ontario provided an update of the progress to date from eHealth Ontario, (a copy of which forms Appendix "D" to the minutes of this meeting) as a policy of the College.

COUNCIL AWARD PRESENTATION

Dr. Eric Stanton presented the Council Council Award to Dr. Mohit Bhandari of Hamilton, Ontario.

FOR DECISION

Alternatives to Degrees in Medicine from Schools Listed in the World Director of Medical Schools Published by the World Health Organization (WHO)

05-C-12-2016

It is moved by Dr. James Watters and seconded by Mr. Emile Therien that:

The Council adopt the policy "Alternatives to Degrees in Medicine from Schools Listed in the World Directory of Medical Schools published by the World Health Organization", (a copy of which forms Appendix "D " to the minutes of this meeting) as a policy of the College.

CARRIED

Restricted Certificate of Registration for Exam Eligible Candidates

06-C-12-2016

It is moved by Dr. Peter Tadros and seconded by Dr. Barbara Lent that:

The Council approve the revised policy "Restricted Certificates of Registration for Exam Eligible Candidates" (a copy of which form Appendix "E" to the minutes of this meeting) as a policy of the College.

CARRIED

Consultation Report on Proposed Changes to OHPIP Standards – Accountability of Medical Director, Staff Qualifications, Infection Control and Quality Assurance

07-C-12-2016

It is moved by Dr. Eric Stanton and seconded by Dr. El-Tantawy Attia that:

The Council approve the revisions to Sections 2, 5, 7 and 8 of the "Out-of-Hospital Premises Inspection Program (OHPIP) Standards" as identified in and incorporated into Appendix A to the briefing note, a copy of which forms Appendix "F" to the minutes of this meeting).

DISCUSSION - OPIOIDS

Maureen Boon, Director of Strategy, provided an overview of the recent developments and the current status of the ongoing working at the CPSO.

REGISTRAR'S REPORT

Strategic Update – Dashboard

Dr. Rocco Gerace provided an update on the Strategic Priorities Report and Dashboard.

ADJOURNMENT

The President adjourned the meeting at 2:45 p.m.

_____
Dr. Joel Kirsh, President

_____
Ms. Franca Mancini, Recording Secretary

DRAFT **PROCEEDINGS OF THE**
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
DECEMBER 2, 2016

Members:

Dr. Joel Kirsh (President)
Dr. El-Tantawy Attia (PhD)
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Ms. Diane Doherty
Mr. Harry Erlichman
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Major Abdul Khalifa
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Mr. Ron Pratt
Dr. John Rapin
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Eric Stanton
Dr. Peter Tadros
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watters

Non-voting Academic Representatives on Council: Dr. Akbar Panju and Dr. Robert (Bob) Smith

Regrets: Dr. John Jeffrey, Dr. Richard (Rick) Mackenzie, Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

Dr. Joel Kirsh called the meeting to order at 9 a.m.

Report of the Finance Committee

Mr. Pierre Giroux presented the report of the activities of the Finance Committee.

Budget 2017:

08-C-12-2016

It is moved by Mr. Peter Pielsticker and seconded by Mr. Sudershen Beri that:

The Council approve the "Budget for 2017" (a copy of which forms Appendix "G" to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2017.

CARRIED

Fee Increase:

09-C-12-2016

It is moved by Dr. Jerry Rosenblum and seconded by Dr. Barbara Lent that:

the Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 111, after circulation to stakeholders:

By-law No. 111

Subsections 4(a) and (c) of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked and the following is substituted:

Annual Fees

4. Annual fees for the year beginning June 1, 2017, are as follows:

(a) $1625 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;

(c) For a holder of a certificate of authorization, $175 per year.

CARRIED

Per Diems Increase:

10-C-12-2016

It is moved by Ms. Diane Doherty and seconded by Mr. Peter Pielsticker that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 112:

By-law No. 112

Paragraphs 20(3)(a)(i),(ii), and (iii) of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked and the following are substituted, effective January 1, 2017:

Council and Committee Remuneration

20.-(3) The amount payable to members of the council and a committee is, subject to subsection (4),

(a) for attendance at, travel to, and preparation for, meetings to transact College business,
(i) $621 per half day for the president,
(ii) $510 per half day for the vice-president, and
(iii) $480 per half day for the other members, and

CARRIED

Cost Awards in Discipline Hearings:

11-C-12-2016

It is moved by Dr. Peeter Poldre and seconded by Dr. Eric Stanton that:

The Council of the College of Physicians and Surgeons of Ontario amends the Discipline Committee's Tariff Rate for Costs and Expenses for the College to Conduct a Day of Hearing, increasing the Tariff Rate to $5,500, effective January 1, 2017.

CARRIED

Application Fee Increases for 2017:

12-C-12-2016

It is moved by Dr. Carol Leet and seconded by Dr. John Langs that:

the Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 113, after circulation to stakeholders:

By-law No. 113

1. Subsections 1(a), (d) and (f) of By-Law No. 2 (the Fees and Remuneration By-law) are revoked and the following are substituted:

APPLICATION FEES

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);
(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);
(f) For a certificate of authorization, $400.00;

2. Section 1 of By-Law No. 2 (the Fees and Remuneration By-law) is amended by deleting the "." at the end of subsection 1(g), substituting it with a ";", and adding the following as new subsection 1(h):

APPLICATION FEES

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application in three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b) or (d).

3. Section 16 of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and the following is substituted:

16. There is a $75 fee for the College to issue a certificate of professional conduct for a member.

Explanatory Note: - This by-law must be circulated to the profession and will return to the Council after the circulation.

Governance Committee Report- Part 1

Dr. Carol Leet presented the first part of the Governance Committee report relating to Council's performance assessment report for 2016.

Nomination Guidelines:

13-C-12-2016

It is moved by Ms. Diane Doherty and seconded by Dr. Jerry Rosenblum that:

The Council approve the revised “Nominations Guidelines” (a copy of which forms Appendix “H” to the minutes of this meeting).

CARRIED

MEMBER TOPICS

No member topics.

PUBLIC MEMBERS REPORT

Mr. Ron Pratt presented the Public Members Report.

ANNUAL COMMITTEE REPORTS

Council reviewed the following Annual Committee Reports:

Discipline Committee
Education Committee
Executive Committee
Fitness to Practise Committee
Governance Committee
Inquiries, Complaints and Reports Committee
Methadone Committee
Outreach Committee
Patient Relations Committee
Premises Inspection Committee
Quality Assurance Committee
Registration Committee

TOPICS FOR INFORMATION

Policy Report

Medical Assistance in Dying Update

Government Relations Report

Updated: Independent Health Facilities Clinical Practice Parameters and Facility Standards for Sleep Medicine

2016 District Council Elections

Registration Program Evaluation: Project Update

Discipline Committee – Report of Completed Cases – December 2016

14-C-09-2016

It is moved by Dr. Attia El-Tantawy and seconded by Dr. Eric Stanton that:

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

CARRIED

IN CAMERA

Council entered into an in-camera session at 11:15 a.m. and returned to open session at 12:05 p.m.

PRESIDENT'S TOPICS

Presidential Address

Dr. Joel Kirsh delivered his Presidential Address to Council and reflected on his experiences during his year as President. He thanked his fellow Council members for their time, particularly Dr. Eric Stanton, Dr. Peter Tadros, Dr. Ron Wexler, Dr. John Jeffrey, Mr. Ron Pratt and Dr. El-Tantawy Attia, whose terms on Council had come to an end. Dr. Kirsh thanked the Registrar and College staff for their support throughout his presidential term on Council.

Induction of New President: Dr. David Rouselle

Dr. Kirsh presented Dr. Rouselle with a President's pin and the chains of office.

Induction of New Members of Council

Dr. Rouselle presented Council pins to Dr. Deborah Hellyer, Dr. Rob Gratton, Dr. Scott Wooder and Dr. Janet van Vlymen and invited them to take their seats at the Council table.

GOVERNANCE COMMITTEE REPORT: Part II

Dr. Carol Leet, Chair, Governance Committee, presented Part II of the Governance Committee Report.

Election of Governance Committee

15-C-12-2016
It is moved by Dr. Marc Gabel and seconded by Dr. James Watters, that:

The Council appoints Dr. Brenda Copps (as physician member), Ms. Diane Doherty) as public member) and Mr. John Langs (as public member), to the Governance Committee for 2016-17.

CARRIED.

Committee Membership Appointments for 2016-2017

16-C-12-2016
It is moved by Dr. Dennis Pitt, and seconded by Mr. Peter Pielsticker that the Council appoints the following people to the following committees:

Council Award Selection Committee:

Ms. Lynne Cram
Dr. Marc Gabel
Dr. Joel Kirsh
Dr. Carol Leet
Dr. David Rouselle

Discipline Committee:

Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Paul Casola
Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Dr. Gordon Dickie
Ms. Diane Doherty
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. William L.M. King
Dr. Joel Kirsh
Dr. Danny Kraftcheck
Mr. John Langs
Dr. Barbara Lent
Dr. Cheryl Levitt
Dr. Bill McCready
Dr. Veronica Mohr
Dr. Tracey Moriarity
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Dr. John Rapin
Mr. Arthur Ronald
Dr. Harvey Schipper
Dr. Robert Sheppard
Dr. Fay Sliwin
Dr. Eric Stanton
Dr. Peter Tadros
Dr. Andrew Turner
Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Scott Wooder
Dr. Sheila-Mae Young
Dr. Paul Ziter

Education Committee:

Dr. Barbara Lent
Dr. Brenda Copps
Dr. Joel Kirsh
Dr. Akbar Panju
Ms. Joan Powell
Dr. Karen Smith

Dr. Robert Smith
Dr. Janet van Vlymen
Dr. James Watters

Finance Committee:

Dr. Steven Bodley
Mr. Harry Erlichman
Mr. Pierre Giroux
Mr. Peter Pielsticker
Dr. Jerry Rosenblum
Dr. David Rouselle

Fitness to Practise Committee:

Dr. Steven Bodley
Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Ms. Diane Doherty
Dr. Marc Gabel
Ms. Debbie Giampietri
Dr. Paul Garfinkel
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. William L.M. King
Dr. Barbara Lent
Dr. Bill McCready
Dr. Tracey Moriarity
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. John Watts
Dr. Paul Ziter

Governance Committee:

Dr. Steven Bodley
Dr. Joel Kirsh
Dr. David Rouselle
Dr. Brenda Copps
Ms. Diane Doherty (public member of Council)
Mr. John Langs (public member of Council)

Inquiries, Complaints and Reports Committee:

Dr. Scott Allan
Dr. George Arnold
Dr. Haig Basmajian
Dr. Mary Bell
Dr. Amanda Black
Dr. Harvey Blankenstein
Dr. Brian Burke

Dr. Bob Byrick
Dr. Angela Carol
Dr. Anil Chopra
Ms. Lynne Cram
Dr. Nazim Damji
Dr. Naveen Dayal
Dr. William Dunlop
Dr. James Edwards
Mr. Harry Erlichman
Dr. Rob Gratton
Dr. Andrew Hamilton
Dr. Christine Harrison
Dr. Keith Hay
Dr. Elaine Herer
Dr. Robert Hollenberg
Dr. Nasimul Huq
Dr. Francis Jarrett
Dr. John Jeffrey
Dr. Carol Leet
Dr. Edith Linkenheil
Dr. Haidar Mahmoud
Dr. Jack Mandel
Dr. Edward Margolin
Dr. Bill McCauley
Dr. Robert McMurtry
Dr. Patrick McNamara
Dr. Dale Mercer
Dr. Lawrence Oppenheimer
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Peter Prendergast
Dr. Anita Rachlis
Dr. Jerry Rosenblum
Dr. Nathan Roth
Dr. Leonard Schwartz
Dr. Ken Shulman
Dr. Wayne Spotswood
Dr. Michael Szul
Mr. Emile Therien
Dr. Lynne Thurling
Dr. Donald Wasylenki
Dr. Stephen White
Dr. Stephen Whittaker
Dr. Lesley Wiesenfeld
Dr. Jim Wilson
Dr. Preston Zuliani

Methadone Committee:

Dr. Steven Bodley
Dr. Lisa Bromley
Ms. Diane Doherty
Dr. Michael Franklyn
Dr. Trevor Gillmore
Dr. Kumar Gupta
Dr. Barbara Lent
Dr. Meredith MacKenzie

Outreach Committee:

Dr. Steven Bodley
Ms. Lynne Cram
Dr. Marc Gabel
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Jerry Rosenblum
Dr. David Rouselle

Patient Relations Committee:

Dr. Pauline Abrahams
Dr. Philip Cheifetz
Dr. Timothy Frewen
Ms. Julie Kirkpatrick
Ms. Lisa McCool-Philbin

Premises Inspection Committee:

Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Bob Byrick
Dr. Wayne Carman
Dr. John Davidson
Dr. Bill Dixon
Dr. Marjorie Dixon
Dr. James Forrest
Dr. Pawan Kumar
Dr. Gillian Oliver
Mr. Peter Pielsticker
Dr. Dennis Pitt
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watson
Dr. Michael Zitney

Quality Assurance Committee:

Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Dr. Jacques Dostaler
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Natasha Graham
Dr. Hugh Kendall
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Bill McCready
Mr. Peter Pielsticker
Dr. Deborah Robertson
Dr. Patrick Safieh
Dr. Bernard Seguin
Dr. Robert Smith
Dr. Leslie Solomon
Dr. Eric Stanton
Dr. Tina Tao
Dr. Smiley Tsao
Dr. Janet van Vlymen
Dr. James Watters

Registration Committee:

Dr. Bob Byrick
Dr. Barbara Lent
Mr. Harry Erlichman
Dr. John Jeffrey
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Jay Rosenfield

CARRIED

ADJOURNMENT

The President adjourned the meeting at 2:05 p.m.

_____
Dr. Joel Kirsh, President

_____
Ms. Franca Mancini, Recording Secretary

PROCEEDINGS OF THE
***DRAFT* SPECIAL TELCONFERENCE MEETING OF COUNCIL**
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 16, 2016 at 12:30pm

Attendees:

Dr. David Rouselle (President)
Mr. Sudershen Beri (via telephone)
Dr. Steven Bodley (via telephone)
Dr. Brenda Copps (via telephone)
Ms. Lynne Cram
Ms. Diane Doherty
Dr. Marc Gabel (via telephone)
Ms. Debbie Giampietri
Mr. Pierre Giroux (via telephone)
Dr. Rob Gratton (via telephone)
Ms. Deborah Hellyer (via telephone)
Major Abdul Khalifa (via telephone)
Dr. Joel Kirsh (via telephone)
Dr. John Langs (via telephone)
Dr. Carol Leet (via telephone)
Dr. Barbara Lent (via telephone)
Dr. Dennis Pitt
Dr. Peeter Poldre (via telephone)
Ms. Joan Powell
Dr. John Rapin
Mr. Emile Therien (via telephone)
Dr. James Watters (via telephone)
Dr. Scott Wooder (via telephone)

Non-voting Academic Representatives on Council: Dr. Janet van Vlymen

Regrets:
Dr. Harry Erlichman
Dr. Rick Mackenzie
Dr. Haider Mahmoud
Dr. Akbar Panju
Dr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Dr. Robert Smith
Dr. Andrew Turner

By-laws for fee increases:

The purpose of this special council meeting is to discuss the By-laws for fee increases. Amendments are needed to proposed By-law No. 111 and proposed By-law No. 113 considered by Council at the meeting on December 2, 2016 in order to separate the fee increases which require circulation to the membership from those that do not. A separate By-law No. 114 is proposed to make the increases in the annual fee and the application fee for Certificates of Authorization effective as of January 1, 2017.

17-C-12-2016

It is moved by Ms. Diane Doherty and seconded by Ms. Debbie Giampietri that the Council of the College of Physicians and Surgeons of Ontario amends proposed By-law No. 111 and proposed By-law No. 113 as follows:

1. Proposed By-Law No. 111 (to revise By-Law No. 2, the Fees and Remuneration By-law) is amended by deleting the content of the proposed By-law and substituting it with the following:

By-law No. 111

Subsection 4(a) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted:

Annual Fees

4. Annual fees for the year beginning June 1, 2017, are as follows:

(a) $1625 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;

Explanatory Note: - This by-law must be circulated to the profession and will return to the Council after the circulation.

2. Proposed By-Law No. 113 (to revise By-Law No. 2, the Fees and Remuneration By-law) is amended by deleting Section 1 of the proposed By-law and substituting it with the following (the rest of proposed By-Law No. 113 remains unamended):

By-law No. 113

1. Subsections 1(a) and (d) of By-Law No. 2 (the Fees and Remuneration By-law) are revoked and the following are substituted:

APPLICATION FEES

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

CARRIED.

18-C-2016

It is moved by Ms. Lynne Cram and seconded by Ms. Joan Powell that the Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 114:

By-law No. 114

1. Subsection 1(f) of By-Law No. 2 (the Fees and Remuneration By-law) is revoked and the following is substituted, effective January 1, 2017:

Application Fees

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(f) For a certificate of authorization, $400.00;

2. Section 4 of By-Law No. 2 (the Fees and Remuneration By-law) is amended by revoking subsection 4(c), adding "and" at the end of subsection 4(a), deleting "; and" at the end of subsection 4(b) and substituting it with a ".", effective January 1, 2017.

3. By-Law No. 2 (the Fees and Remuneration By-law) is amended by adding the following as Section 4.1, effective January 1, 2017:

Annual Fees

4.1 Annual fees for a holder of a certificate of authorization, for the year beginning January 1, 2017, are $175 each year.

Explanatory Note: - This proposed by-law does not need to be circulated to the profession.

CARRIED.

Adjournment

As there was no further business, the President adjourned the meeting at 12:45pm.

Dr. David Rouselle, President

Franca Mancini, Recording Secretary

February 2017

EXECUTIVE COMMITTEE'S REPORT TO COUNCIL
November 2016 – December 2016
In Accordance with Section 12 HPPC
The College of Physicians and Surgeons of Ontario

November 1, 2016 EXECUTIVE COMMITTEE MEETING

1. Planning for and Providing Quality End-of-Life Care Policy – Organ and Tissue Donation

At its September meeting, Council was asked by the Trillium Gift of Life Network (TGLN) to take steps to further support organ and tissue donation. In particular, the TGLN asked the CPSO to endorse its message that, when considered eligible, *all* patients/families be given the opportunity to speak with an expert in donation in a timely way.

The Executive Committee chose not to consider amendments to the *Planning for and Providing Quality End-of-Life Care* policy at this time, indicating that the policy already addresses these issues in a manner that is consistent with TGLN's request.

The Executive Committee directed that an article be drafted for *Dialogue* that emphasizes the importance of organ and tissue donation, identifies it as a part of quality end-of-life care, and that explores barriers to timely referrals.

November 25, 2016 EXECUTIVE COMMITTEE MEETING

1. Letter to Health Canada re Mifegymiso (RU-486) - Medical Abortion

In July 2015, Health Canada approved Mifegymiso to be available in Canada (expected availability in January 2017). Mifegymiso achieves a medical abortion; the medication induces a miscarriage-like process and no surgical intervention is required. The product monograph approved by Health Canada provides that Mifegymiso would only be prescribed and dispensed by physicians. The requirement for physician-only dispensing has garnered significant criticism and concerns that it will impede access, as very few physicians dispense drugs.

The Executive Committee agreed to support a plan for the CPSO and the Ontario College of Pharmacists (OCP) to write a letter jointly to Health Canada in December, in advance of Mifegymiso being available to the public in January 2017:

(a) seeking confirmation that Ontario physicians and pharmacists can rely on the direction provided to BC: that pharmacist-dispensing of Mifegymiso will be acceptable and considered 'off-label';

(b) requesting that Health Canada consider amending the monograph so that it would no longer be "off-label"; and

(c) addressing the issue of dispensing only; Mifegymiso would still be prescribed by physicians, and physicians would be responsible for follow up care to patients.

The Executive Committee was advised that the Society of Obstetricians and Gynaecologists is developing training material for physicians who will be prescribing Mifegymiso. The Executive Committee acknowledged this as an important element in managing the introduction of this drug to the Canadian public.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **Uninsured Services: Billing and Block Fees – Draft for Consultation**

DATE: **February 2017**

FOR DECISION

ISSUE:

- The College's Block Fees and Uninsured Services policy is currently under review. After considering the research undertaken to date, as well as the feedback received during the preliminary consultation, a new draft policy entitled Uninsured Services: Billing and Block Fees has been developed.

- Council is provided with an overview of the policy review process undertaken to-date, as well as a copy of the draft policy. Council is asked whether the draft policy can be released for external consultation.

BACKGROUND:

- The College's Block Fees and Uninsured Services policy is currently under review in accordance with the College's regular policy review cycle.

- The policy, which was originally approved by Council in 2000, and last updated in 2010, sets out key principles and expectations for physicians charging for uninsured services and/or offering a block fee.

- The policy review was undertaken with the assistance of Dr. Michael Szul (Medical Advisor) and Morgana Kellythorne (Legal Counsel) and Council members Dr. Barbara Lent and Mr. Arthur Ronald.

- The draft policy presented for Council's consideration has been informed by extensive research and external consultation. Highlights of the issues and content considered as part of the review are set out below.

A. Research

- A comprehensive literature review of scholarly articles, research papers, and media publications as well as a jurisdictional review of other medical regulatory authorities in Canada was undertaken. Moreover, decisions of the Inquiries, Complaints, and

Reports Committee (ICRC) were reviewed to identify frequent or persistent problems. A number of key themes emerged from this review, including:

- A general consensus that patients may still be unaware that some physician services are uninsured and that physicians should be proactive in communicating this fact. Relatedly, some opinion pieces suggested that patients continue to believe that block fees are mandatory.

- That the reasonableness of a fee must be considered in relation to the patient's ability to pay. Notably, the Ontario Medical Association (OMA), Canadian Medical Association (CMA), and various Canadian medical regulatory authorities embrace this idea in principle and a number of patient advocate groups expressed this sentiment in both research documents and opinion pieces as well.

- That block fees are being offered in settings where it may not be appropriate. Evidence of this was presented in a research document developed by a patient advocacy group. Importantly, the OMA explicitly informs physicians that block fees are not appropriate in all practice settings and ICRC decisions have embodied this notion on occasion as well.

- With support from Legal Counsel, a review of relevant legislation, case law, and supporting materials produced by the government were reviewed to identify opportunities for improved clarity or precision in the policy.

B. Preliminary Consultation

Consultation Process

- In accordance with standard practice, an external preliminary consultation[1] was held on the current policy beginning September 11, 2015.

- In total, the College received 116 responses.[2] This included 44 written comments and 72 online surveys.[3] All stakeholder feedback has been posted publicly on the consultation-specific page of the College's website.

[1] Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the College's entire membership. In addition, a general notice was posted on the College's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and Patient Compass (the College's public e-newsletter). Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via an online survey, or by posting comments to an online discussion page.

[2] Approximately 76% of respondents to the consultation identified themselves as physicians, 15% as members of the public, 3% as organizations, and 16% as anonymous or prefer not to say. The organizational respondents were: Canadian Doctors for Medicare, College of Medical Laboratory Technologists of Ontario, College of Physicians and Surgeons of Saskatchewan, and Professional Association of Residents of Ontario.

[3] 75 respondents started the survey, but of these, 3 did not complete any substantive questions – leaving 72 for analysis.

- Broadly speaking, stakeholders expressed support for the current policy. In particular, the majority of online survey respondents felt that the current policy was clearly written, easy to understand and that the expectations contained in the current policy were appropriate and reasonable.

- However, many physician stakeholders suggested that physicians should be free to set their own rates for uninsured services and that neither the OMA nor the College should be involved in setting or regulating these fees.

- A number of stakeholders offered substantive suggestions for revisions to the current policy. Most notably:

    - Including a clear statement that physicians have a right to charge for uninsured services.

    - Providing additional clarity or specificity with respect to what constitutes a "reasonable" fee or what is "reasonable" for a block fee.

    - Requiring physicians to consider the patient's ability to pay when determining what is reasonable, and to be willing to reduce or waive fees where appropriate.

    - Recognizing the power imbalance inherent in the physician-patient relationship, how this may lead patients to pay fees they cannot afford or to agree to pay a block fee when it is not in their best interest to do so, and how these factors may compromise the altruistic and transparent nature of the physician-patient relationship.

    - Providing guidance for those specialties that frequently provide uninsured services, but where the OMA guidelines and the College policy regarding block fees are not relevant or helpful.

    - Addressing problems that arise when procedures are comprised of both insured and uninsured elements (e.g. cataract surgery), and in particular, how the uninsured options are being characterized (e.g. as mandatory, as the safer/better option).

<u>Public Polling</u>

- In addition to the public consultation, a public opinion poll[4] was undertaken between May 19th and May 26th, 2015 to explore issues relating to block fees.

[4] In total 920 Ontarians were surveyed (a representative sample of 800 Ontarians plus an oversample of 120 Ontarians who had previously been asked to pay a block fee), resulting in a margin of error of +/- 3.5%, at the 95% confidence level.

- Polling results indicate that block fees are only being offered to a small proportion of Ontarians and that patients tend not to select this option. Importantly, the results also indicate that physicians are generally complying with the expectations set out in the current policy. More specifically:

    - Only 20% of Ontarians say they have been asked to pay a block fee and only 37% of these individuals opted to pay the block fee.

    - Of those who were offered a block fee, a strong majority said it was clear that payment was voluntary (86%) and that there was an alternative payment option available to them (86%).

    - Moreover, a strong majority indicated that their physician *did not* require payment of the block fee before services would be provided (87%) and the vast majority indicated that their physician *did not* offer them preferential access to care in exchange for payment of the block fee (97%).

CURRENT STATUS:

- Building upon on the research and feedback gathered to-date, a draft Uninsured Services: Billing and Block Fees policy has been developed (**Appendix A**).

- Overall, the draft policy retains the key content and central principles of the current policy. However, a number of changes have been made to enhance clarity and flow, strengthen existing expectations, or to address issues currently not addressed by the policy. The key revisions and additions reflected in the draft policy are set out below.

<u>Key revisions and additions</u>

1) The scope of policy has been clarified and further defined:

- The draft policy title has been revised to more clearly indicate that the draft policy sets out expectations regarding uninsured services, construed broadly, and that block fees are just one component of charging for uninsured services.

- A scope section has been added to the draft policy to further clarify that the principles and expectations set out in the draft policy apply in all contexts where uninsured services are provided (Lines 43-48).

- The draft policy does not, however, provide specific advice for those specialties that frequently provide uninsured services, but where the OMA guidelines are not relevant. The draft policy is not intended to tell physicians how much to bill, but rather, is intended to set out general principles of professionalism and relevant legislative obligations.

2) **Additional clarity and expectations regarding the reasonableness of fees has been provided:**

- In response to both research and feedback, the draft policy now provides significantly more guidance regarding how to determine what constitutes a reasonable fee.

- Most notably, the draft policy now requires physicians to consider the patient's ability to pay and in particular, to give consideration to whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds (Lines 87-92). This expectation is comparable to positions set out by the OMA, CMA,[5] and other Canadian medical regulatory authorities.[6]

3) **New expectations regarding communicating fees:**

- A new section setting out specific expectations relating to the communication of fees has been added (Lines 94-114).

- The draft policy now requires physicians to communicate any fees that will be charged in advance of providing the service and encourages physicians to take proactive steps to both educate and inform patients regarding fees for uninsured services (e.g., making a list of fees available in advance, posting a notice in their office, getting staff involved).

- The draft policy also sets out expectations for when insured and uninsured services are being proposed or provided together or when uninsured services are being offered as an alternative to insured services. More specifically, the draft policy requires physicians to clearly indicate for which services the fee is being charged and to clearly and impartially describe the differences between insured and uninsured treatment options (Lines 97-104).

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[5] The CMA Code of Ethics #16 states that: "In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay."

[6] For example, the College of Physicians and Surgeons of New Brunswick's guideline on Charging for Uninsured Services articulates the principle that physicians "Consider, in determining professional fees, both the nature of the service provided and the ability of the patient to pay." The College of Physicians and Surgeons of Alberta's standard Charging for Uninsured Professional Services states that amounts charged for uninsured services "must reasonably reflect physician professional costs, administrative costs and the patient's ability to pay." Finally, the College of Physicians and Surgeons of Manitoba's Bylaw 11 – Standards of Practice 69(4) notes that physicians who offer block fees "may waive or reduce any fee according to the patient's ability to pay."

4) **Expectations regarding billing for missed or cancelled appointments have been provided:**

- Following other Canadian medical regulatory authorities,[7] the draft policy now sets out specific requirements that must be in place before a physician may bill for a missed or cancelled appointment (i.e., have a system in place to facilitate the cancellation process, have informed the patient in advance, and have been available at the time of the appointment to see the patient) (Lines 116-123).

- The draft policy also requires physicians to consider the patient's ability to pay the fee and to consider granting exceptions where it would be reasonable to do so (e.g., first or isolated incident) or on compassionate grounds (Lines 126-128).

5) **Additional clarity and expectations regarding the offering and management of block fees has been provided:**

- On the basis of stakeholder feedback, research, College investigations, and a review of sample block fee letters, the expectations regarding when and how a block fee can be offered have been updated and expanded.

- The draft policy now states that a block fee may not be appropriate in all practice settings where uninsured services are provided, noting that appropriateness will depend on a number of factors including, but not necessarily limited to, the nature of the physician-patient relationship (Lines 145-148). This language was adapted from the OMA and is consistent with recommendations of ICRC.

- A number of new or strengthened expectations relating to offering a block fee have been developed (Lines 166-189). Most notably, the draft policy now requires physicians to:

    - Explicitly indicate to the patient that payment of a block fee is optional and that their decision will not affect their access to care;

    - Invite patients to consider whether payment of a block fee is in their best interest and to be available to help patients make this assessment; and

    - Refrain from using language that is or could be perceived as coercive or which is suggestive that services may be reduced or quality of care may suffer if the block fee is not paid.

[7] For example, similar requirements are set out by both the College of Physicians and Surgeons of New Brunswick and Prince Edward Island.

CONSIDERATIONS

- A Patient Information Sheet is provided as an appendix to the current Block Fees and Uninsured Services policy in order to restate key policy expectations in a manner that is more accessible to the general public.

- As the expectations of the draft policy are not yet final, the production of an updated Patient Information Sheet has been postponed until after the consultation and when a revised draft policy is brought forward to Council for review and feedback.

NEXT STEPS

- In keeping with College policy processes, the next stage in the review process is to solicit feedback on the draft policy externally, through a consultation with the profession, the public, and other interested stakeholders.

- Subject to Council's approval, the consultation will be held following the February 2017 Council Meeting and stakeholder feedback will be shared with both the Executive Committee and Council in the Spring of 2017.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the draft Uninsured Services: Billing and Block Fees policy?

2. Does Council recommend that the draft policy be released for external consultation?

CONTACT: Craig Roxborough, Ext. 339

DATE: February 3, 2017

Attachments:

Appendix A: *Uninsured Services: Billing and Block Fees* Draft Policy

Uninsured Services: Billing and Block Fees

Introduction

Some services provided by physicians are not covered by the Ontario Health Insurance Plan (OHIP). These are often referred to as uninsured services and may include services such as sick notes for work, the copy and transfer of medical records, prescription refills and medical advice over the phone, the completion of insurance and/or medical forms, and even some medical procedures.

Physicians are entitled to charge patients for uninsured services, and in some instances, may elect to offer patients the option of paying for uninsured services through a block fee.

The purpose of this policy is to set out the College's expectations of physicians who charge for uninsured services and/or offer the option of a block fee.

Principles

The key values of professionalism articulated in the College's Practice Guide – compassion, service, altruism and trustworthiness – form the basis for the expectations set out in this policy. Physicians embody these values and uphold the reputation of the profession by:

1. Respecting patient autonomy regarding payment decisions for uninsured services;
2. Acting in the best interests of their patients;
3. Communicating effectively with patients to foster a trusting physician-patient relationship;
4. Practising altruistically by helping patients understand their options regarding payment for uninsured services;
5. Maintaining public trust in the profession by ensuring that patient decisions regarding payment for uninsured services do not pose a barrier to accessing health care services or negatively affect the physician-patient relationship;
6. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

Definitions

Insured services:

Services listed in the *Health Insurance Act* and the Schedule of Benefits that are publicly funded under OHIP,[1] provided that the service is being rendered to an insured person.[2,3]

All insured services include the provision of the service itself, as well as any constituent elements associated with the service. Examples of constituent elements of insured services include the referral of a patient to a specialist, the administrative processing for a new patient being accepted into a practice, and making arrangements for an appointment.[4]

Uninsured services:

Services which are not publicly funded under OHIP, and which may be directly billed to the patient or a third party.[5] This includes physician services provided to uninsured individuals.

Block fee:

A block fee is a flat fee charged to patients for a predetermined set of uninsured services during a predetermined period of time. This flat fee may also be referred to as an 'annual fee' if it covers a period of 12 months.[6]

Scope

This policy articulates the College's expectations of physicians who charge for uninsured services and/or offer patients the option of paying for uninsured services by way of a block fee. These expectations apply regardless of practice area or specialty and regardless of the type of

[1] The services paid for by the Ontario Health Insurance Plan (OHIP) are set out in Section 11.2 of the *Health Insurance Act,* R.S.O. 1990, c. H.6 (hereinafter, *Health Insurance Act*) and the Schedule of Benefits: Physicians Services under the *Health Insurance Act* (hereinafter, Schedule of Benefits).

[2] An insured person is entitled to insured services as per provincial legislation and regulations. In Ontario the *Health Insurance Act* and its regulations set out the definition of insured persons who are covered by OHIP.

[3] The College acknowledges that individuals not covered by OHIP, may be covered by other insurance programs such as the Interim Federal Health Programme (which provides basic health care for refugees or refugee claimants), the Non-Insured Health Benefits program (which provides coverage for certain services to eligible First Nations and Inuit people), or by another provincial health insurance plan. As there are unique requirements, processes, and challenges related to each of these programs, for the purposes of this policy, the definitions of insured and uninsured services or persons are framed in relation to the *Health Insurance Act* and OHIP.

[4] For a complete list of the common and specific elements of insured services that are considered to be constituent elements of the insured medical services covered by OHIP, see the preamble of the Schedule of Benefits.

[5] For example, a representative from an insurance company or a lawyer. For more information see the Third Party Reports policy.

[6] This does not prevent physicians from calling a flat fee charge for a predetermined set of uninsured services by another name (i.e., 'Patient Supplemental Plan', 'Block Billing Plan', etc.), provided that it is not misleading.

uninsured services charged for. Such services include, but are not limited to, commonplace uninsured services such as sick notes and prescription refills over the phone through to medical procedures that are not or are only partially covered by OHIP.

Policy

Physicians who charge for uninsured services, either individually or by way of a block fee, must comply with the expectations set out in this policy, other relevant College policies,[7] and applicable legislation.[8]

The first section of the policy sets out general expectations for physicians when charging for uninsured services, whether these services are paid for individually or by way of a block fee. The second section of the policy sets out expectations for physicians who offer patients the option of paying for uninsured services by way of a block fee. Expectations for physicians who use a third party to collect payment for uninsured services and/or administer block fees are set out in the final section of the policy.

Charging for Uninsured Services

Determining what can be Charged For

Physicians are entitled to charge for the provision of uninsured services (e.g., sick notes for work, the copy and transfer of medical records, prescription refills and medical advice over the phone, the completion of insurance and/or medical forms, some medical procedures, etc.).

Physicians cannot, however, charge patients for insured services, including the constituent elements of insured services.[9] Additionally, in accordance with regulation, there are a number of restrictions on what physicians may charge patients for. For example, physicians may not charge for services not performed[10] or for an undertaking to be available to provide services to a patient.[11]

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[7] This includes, but is not limited to, the Medical Records and Third Party Reports policies, as both touch on the issue of billing for uninsured services.

[8] This includes, but is not limited to, the *Health Insurance Act*; the *Professional Misconduct*, O. Reg. 856/93 enacted under the *Medicine Act, 1991,* S.O. 1991, C.30 (hereinafter, *Professional Misconduct Regulation*); and the *Commitment to the Future of Medical Care Act, 2004,* S.O. 2004, c.5 (hereinafter, *CFMA, 2004*).

[9] A physician may charge patients for services if the physician opted out of OHIP prior to December 23, 2004; the patient is not eligible for OHIP insurance; or if the services are not insured services which would otherwise be paid for by OHIP.

[10] Section 1(1) paragraph 20 of the *Professional Misconduct Regulation*. Notwithstanding the prohibition on charging for services not performed, physicians are permitted to charge for missed or cancelled appointments in specific circumstances. See Section 1(1) paragraph 20 of the *Professional Misconduct Regulation* or below for more information.

[11] Section 1(1) paragraph 23.2 of the *Professional Misconduct Regulation*.

Setting Fees that are Reasonable

Physicians must ensure that the fees charged for uninsured services are reasonable. In accordance with regulation, it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided.[12] This requirement applies to fees set for individual uninsured services, but also applies to block fees. More specifically, the amount charged for the block fee must be reasonable in relation to the services covered by the block fee.

When determining what is reasonable to charge for individual uninsured services, physicians must ensure that the fee is commensurate with the nature of the services provided and their professional costs.

In making this determination, physicians must review the most recent version of the Ontario Medical Association's *Physician's Guide to Uninsured Services* ("the OMA Guide"), which sets out a recommended schedule of fees for common uninsured services and provides guidance for setting fees when a recommended fee is not provided. While physicians are not obliged to adopt the schedule of fees set out in the OMA Guide, in accordance with regulation, if a physician intends to charge more than the current schedule of fees they must notify the patient before the service is provided of the excess amount that will be charged; failure to do so is an act of professional misconduct.[13]

In addition to ensuring that the fee is commensurate with the nature of the services provided and the physician's professional costs, when determining what is reasonable to charge for individual uninsured services, physicians must consider the patient's ability to pay.[14] 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.

Communicating Fees

Physicians must inform a patient or third party[15] of any fee that will be charged prior to providing an uninsured service, except in the case of emergency care where it is impossible or impractical to inform the patient.

[12] Section 1(1) paragraph 21 of the *Professional Misconduct Regulation*.
[13] Section 1(1) paragraph 22 of the *Professional Misconduct Regulation*.
[14] The Canadian Medical Association Code of Ethics #16 states that "In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient."
[15] See footnote 5 or the Third Party Reports policy for more information.

If insured and uninsured services are being proposed or provided together, physicians must clearly communicate which services are associated with the fee and which are not. Additionally, in those instances where uninsured services are offered as an alternative to or as supplemental to insured services, physicians must clearly and impartially describe the differences between the insured and uninsured options, providing clear and unbiased information about the options available to the patient.[16] Physicians are also reminded that under regulation it is a conflict of interest to sell or otherwise supply any medical appliance or medical product to a patient at a profit.[17]

While physicians are encouraged to actively engage office staff in informing patients or third parties of the fees associated with uninsured services, physicians are ultimately responsible for ensuring that any applicable fees are communicated in advance and must be available to offer explanations and/or answer questions about the fees that will be charged.

Similarly, while a general notice to patients in a physician's office listing fees for common uninsured services can assist in patient education and is recommended, it is not a substitute for informing patients or third parties of fees for uninsured services. Additionally, prior to providing an uninsured service, physicians are advised to provide patients with a copy of this policy and/or the appended Patient Information Sheet or provide instructions on how to access these documents, as this will assist in patient education.

Charging for Missed or Cancelled Appointments

In general, physicians are prohibited from charging for services that are not rendered. However, in accordance with regulation, physicians are permitted to charge for a missed appointment or a cancelled appointment where the cancellation is made less than twenty-four hours before the appointment time, or in a psychotherapy practice, in accordance with any reasonable written agreement with the patient.[18] Physicians who intend to charge patients in these circumstances must: have a system in place to facilitate the cancellation process, ensure that the patient was informed of the cancellation policy and associated fees in advance, and have been available to see the patient at the time of the appointment.

When determining what to charge for missed or cancelled appointments, physicians must ensure that the fee reasonably reflects the costs incurred and be able to justify the amount

[16] It is an act of professional misconduct to make a misrepresentation respecting a remedy, treatment or device (Section 1(1) paragraph 13 of the *Professional Misconduct Regulation*) or to make a claim respecting the utility of a remedy, treatment, device or procedure other than a claim which can be supported by reasonable professional opinion (Section 1(1) paragraph 14 of the *Professional Misconduct Regulation*).

[17] Section 16(d) of *General Regulation*, Part IV, Conflicts of Interest, O. Reg. 114/94 enacted under the *Medicine Act, 1991*, S.O. 1991, C.30

[18] Section 1(1) paragraph 20 of the *Professional Misconduct Regulation*.

billed. Physicians must also consider the patient's ability to pay the fee and consider granting exceptions where it is reasonable to do so (e.g., first or isolated incident, intervening circumstances, etc.) or on compassionate grounds.

Providing an Invoice

Physicians are advised to always provide an itemized invoice[19] for any uninsured services that are provided and for which fees are paid.[20] However, physicians are required to provide an invoice when they are asked for one. In accordance with regulation, failure to provide an itemized invoice when asked is an act of professional misconduct.[21]

Collecting Fees and Outstanding Balances

Sometimes patients may accrue a balance owing for uninsured services received. Physicians may take action[22] to collect any fees owed to them, but must always do so with tact, sensitivity, and in accordance with privacy legislation. In so doing, physicians must consider the patient's ability to pay the outstanding balance and consider whether it would be appropriate to reduce, waive, or allow for flexibility based on compassionate grounds.

Offering a Block Fee

Assessing Whether a Block Fee is Appropriate

Physicians who charge for uninsured services may, but are not required to, offer patients the option of paying for uninsured services by way of a block fee.[23]

A block fee may be a more convenient and/or economical way for patients to pay for uninsured services, and for physicians to administer fees for these services. However, a block fee may not be appropriate in all practice settings where uninsured services are provided. Appropriateness will depend on a number of factors, including but not necessarily limited to, the nature of the physician-patient relationship. It is not permissible to charge a block fee in order to cover

[19] Physicians must not charge for the production of an itemized invoice.
[20] This would include any fees charged for missed or cancelled appointments and fees that are charged to patients who have chosen to pay a block fee, but where the fees for some services are merely reduced as a result.
[21] Section 1(1) paragraph 24 of the *Professional Misconduct Regulation*.
[22] This may include physicians or their office staff contacting patients or hiring a third party (i.e., collection agency) to assist in the process.
[23] Although section 1(1) paragraph 23 of the *Professional Misconduct Regulation* lists "charging a block fee" as an act of professional misconduct, physicians are able to charge a block fee as this provision has been struck down by the courts in *Szmuilowicz v. Ontario(Minister of Health),* 1995 CanLII 10676 (ON SC) and is therefore not in effect.

administrative or overhead costs associated with providing insured services;[24] rather, a block fee is merely a way of facilitating the payment of uninsured services.

Physicians offering a block fee must ensure the fee covers a period of not less than three months and not more than 12 months.

Ensuring Patient Choice and Access to Care

Physicians who offer the option of payment for uninsured services by way of a block fee must always provide patients with the alternative of paying for each service individually at the time that it is provided.

Moreover, patient decisions regarding whether to pay for uninsured services individually or by way of a block fee must not affect their ability, or the ability of others in the physicians' practice, to access health care services. Physicians must not:

- Require that patients pay a block fee before accessing an insured or uninsured service;[25]
- Treat or offer to treat patients preferentially because they agree to pay a block fee;[26] or
- Terminate a patient[27] or refuse to accept a new patient[28] because that individual chooses not to pay a block fee.[29]

To ensure patients are able to make fully informed choices regarding the payment of uninsured services, physicians who choose to offer a block fee must:

1. Offer a block fee in writing.[30] In so doing, physicians must:
    - Indicate that payment of a block fee is optional and that patients may choose to pay for uninsured services individually as they use them;
    - Indicate that the patient's decision to pay for uninsured services individually or through a block fee will not affect their ability to access health care services;

[24] See the "Constituent and Common Elements of Insured Services" of the Schedule of Benefits, read in conjunction with section 37.1 (1) of R.R.O 1990, Reg. 552 General, enacted under the *Health Insurance Act* and Section 10 of the *CFMA, 2004*.
[25] Section 18(2) of the *CFMA, 2004*.
[26] Section 17(1) of the *CFMA, 2004*.
[27] For more specific guidance on ending the physician-patient relationship, refer to the College's Ending the Physician-Patient Relationship policy.
[28] For more specific guidance on accepting new patients, refer to the College's Accepting New Patients policy.
[29] Section 18(2) of the *CFMA, 2004*.
[30] This can include e-communication; however, physicians must provide information to patients by other means (i.e., mailed letter) if their patient(s) do not have access to the internet. Physicians are reminded of the inherent risks in using e-communication with patients and are advised to refer to relevant privacy legislation, policies and guidelines for further direction.

- Identify those services that are covered by the block fee, provide a list of fees that will be charged individually for each of these services should the block fee option not be selected, provide examples of those services (if any) that are not covered, and indicate for which services (if any) the fee is simply reduced if the block fee option is selected; [31]
- Use plain language and refrain from using language that is or could be perceived as coercive or which suggests that without payment of the block fee, services will be limited or reduced, or that quality of care provided in the physicians' practice may suffer;
- Invite patients to consider whether payment of a block fee is in their best interest given their needs or usage of uninsured services; and
- Provide patients with a copy of this policy and/or the appended Patient Information Sheet or provide instructions on how to access these documents. [32]

2. Be available to answer any questions patients have about the physician's billing policy and about any charges the patient does not understand. [33]
3. Be available to help patients assess whether payment of a block fee is in their best interest given their needs or usage of uninsured services. [34]
4. Obtain written confirmation if the block fee option is chosen and maintain it as part of the patient's medical record. [35]

Patients must be given the opportunity to rescind the decision to pay a block fee within a week of their original decision, in which case they would be required to pay for services individually as they are provided. In the event that the patient does rescind their decision to pay a block fee, physicians must refund the amount charged for the block fee and may then charge the patient individually for any uninsured services already provided.

When a patient leaves a practice or is terminated from a practice, or the physician ceases to practice, physicians are advised to consider whether it would be reasonable to refund a portion of the block fee. In so doing, physicians are advised to consider both the time remaining in the block fee and the services that have been provided to date.

[31] Some uninsured services are particularly time consuming (e.g. complex medical reports). Physicians may choose to provide a discounted fee for these services to those patients who elect to pay a block fee.

[32] For example, physicians can refer their patients to the College's Public Advisory Service (1-800-268-7096 ext. 603) or direct patients to the College's website for further information about the College policy.

[33] Physicians using a third party to administer their block fee may rely on the third party to provide assistance to the patient, but physicians must be available to help patients directly and patients must be informed that they can speak with the physician directly.

[34] As with above, physicians may rely on the third party to provide this assistance, but must be available directly to the patient and patients must be informed that they can speak with the physician directly.

[35] For more specific guidance on medical records requirements, refer to the College's Medical Records policy.

Use of Third Party Companies

Physicians may find it helpful to utilize the services of a third party company to assist them in administering and managing block fees or payment for uninsured services more generally. Any communication between the third party company and patients must identify the third party by name and indicate that they are acting on the physician's behalf.

Third parties who administer block fees or manage payment for uninsured services are acting on the physician's behalf. As such, physicians are responsible for ensuring these companies adhere to the same standards required of physicians, as outlined in this policy, other relevant College policies,[36] and applicable legislation.[37]

[36] This includes, but it not limited to, the policies listed in Footnote 7.

[37] This includes, but is not limited to, the legislation listed in Footnote 8 and the *Protection of Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: Governance Committee Report

DATE: February 2017

For Decision

- **Election to fill public member vacancy on 2017 Governance Committee**

ISSUE: Election to fill public member vacancy on 2017 Governance Committee

- There is a vacancy for a public Council member on the Governance Committee.
- A request for nominations has been distributed to Council. If more than one candidate is nominated, an election will take place to fill the position.
- Council is provided with the (January 23, 2017) memo from the Chair of the Governance Committee outlining the election and nomination process to fill the public member vacancy on the 2017 Governance Committee (Appendix A).

DECISION FOR COUNCIL:

1. Vote for one public member to fill vacancy on the 2017 Governance Committee.

Contact: Joel Kirsh, Chair, Governance Committee
Louise Verity, ext. 466
Debbie McLaren, ext. 371

Date: February 3, 2017

Appendices: Appendix A – Memo from Chair of Governance Committee

APPENDIX A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMORANDUM

To: All Council Members

From: Dr. Joel Kirsh, Chair, Governance Committee

Date: **January 23, 2017**

Subject: **Nomination/Election Process for Vote at the February 24, 2017 Council Meeting to fill one public member vacancy on the 2017 Governance Committee**

There is a current vacancy for one public member position on the 2017 Governance Committee.

In order to fill the vacancy, there will be an election and vote by Council at the upcoming Council meeting on February 24, 2017.

The *General By-Law 44-(3)* states the mandate of the Governance Committee:
44-(3) The Governance Committee shall,

(a) monitor the governance process adopted by the Council and report annually to the Council on the extent to which the governance process is being followed;
(b) consider and, if considered advisable, recommend to the Council changes to the governance process;
(c) ensure nominations for the office of president and vice-president
(d) make recommendations to the Council regarding the members and chairs of committees; and
(e) make recommendations to the Council regarding any other officers, officials or other people acting on behalf of the College.

Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the position.

A completed **Nomination Form** is due, prior to the commencement of the February 24 Council meeting, to validate Council's support of candidates. Each nomination requires the signatures of a nominator, a seconder, and the agreement of the nominee. A Council Contact list is being provided separately for you to facilitate your communication with Council members for the vote.

All **public members of Council** who wish to be nominated for the public member elected position on the Governance Committee are encouraged to submit an optional **Nomination Statement. The Nomination Statement is limited to 200 words**. The Nomination Statement will include brief biographical information and a CPSO photo, or alternatively, you may submit your own photo. N**omination Statements that are submitted by the deadline *(February 2, 2017)*** will be circulated to all Council members by e-mail, prior to the February Council meeting, and will be included in the Governance Committee Report to Council.

The Nomination Statement will assist Council members to identify candidates who are running for election, and provide more information regarding a candidate's background, qualifications and reasons for running for the public member position on the 2017 Governance Committee.

I have attached a Nomination Form, and a sample **Nomination Statement** template.

If you wish to be nominated for the 2017 Governance Committee public member position, please contact Debbie McLaren at dmclaren@cpso.on.ca Debbie will complete the section on the **Nomination Statement** regarding your CPSO work, and provide you with a personalized template to fill in your 200 words (or less) statement.

For your reference, a list of current 2016-2017 Governance Committee members is attached.
Please note that public members who are members of the 2016-2017 Executive Committee are ineligible for appointment to the Governance Committee.

1. The deadline for submission of your completed Nomination Statement is: Thursday, February 2, 2017.
2. The deadline for submission of your completed Nomination Form is Friday, February 24, 2017, prior to the commencement of the Council meeting.

Election Process:

1. **If there is more than one nomination for the one public member position, a vote will take place at the February 24th Council meeting.**

2. **Each nominee will have the opportunity to address Council, if they wish, for a maximum of two minutes about his/her candidacy for the position before the vote takes place. Audio/visual presentations will not be accepted.**

If you have any questions regarding the nomination process, please contact Debbie McLaren at dmclaren@cpso.on.ca or by phone: 416-967-2600, ext. 371 or toll free: 1-800-268-7096, ext. 371).

Yours truly,

Joel A. Kirsh MD, MHCM, FRCPC
Chair, Governance Committee

att.
1) 2016-17 Governance Committee
2) Nomination Form
3) Sample - Nomination Statement Template

2016-2017 Governance Committee:

Dr. Joel Kirsh, Chair
Dr. David Rouselle
Dr. Steven Bodley
Dr. Brenda Copps
Mr. John Langs
Vacancy - Public Member of Council

The Governance Committee is composed of, the president, the vice-president and a past president as per the *General By-Law 44.-(1)(a)*

A physician member of Council and two public members of Council who are appointed by Council at the annual meeting, and are not members of the Executive Committee as per the *General By-Law 44.-(1)(b) and 44.-(1)(c)*

A past president chairs the Governance Committee as per the *General By-Law, 44(2)*

GOVERNANCE COMMITTEE

NOMINATION FORM

FOR PUBLIC MEMBER ON THE GOVERNANCE COMMITTEE:

I _____ am willing to be
Print name here

nominated for the Public Member on the Governance Committee.

Signed:_____ _____
Signature of Nominee Date

Nominated by: _____ _____
Signature Date

Seconded by: _____ _____
Signature Date

NOMINATION STATEMENT

CANDIDATE FOR PUBLIC MEMBER
FOR THE 2017 GOVERNANCE COMMITTEE

Public member candidates will be provided with a P*ersonalized* Nomination Statement Template that will contain your brief biographical information (see below) and your photo will be inserted. Please review the information that is provided to you, and type your Nomination Statement in the space provided. Please note that any Nomination Statements over 200 words will be returned to candidates for revision. The submission deadline for completed Nomination Statements is Thursday, February 2, 2017.

To obtain your *personalized* template, contact Debbie McLaren at dmclaren@cpso.on.ca or call 416-967-2600, ext. 371 or toll free, 1-800-268-7096, ext. 371.

Photo inserted here:	**NAME** **Public Member** **City, Ontario** **Occupation:** **Appointed Council Terms:**

CPSO Committees and other CPSO Work:

NOMINATION STATEMENT:
(200 words or less)

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **College Oversight of Fertility Services – Consultation Report and Revised Draft Regulation**

DATE: **February, 2017**

FOR DECISION

ISSUE:

- An amendment to *Ontario Regulation 114/94, Part XI* was circulated for external consultation between September 21 and November 25, 2016.
- Council is provided with a report on the consultation and the proposed revisions made to the draft regulation in response to the feedback received.
- Council is asked whether the revised draft regulation can be approved for submission to government.

BACKGROUND:

- The College has been asked by the Ministry of Health and Long-Term Care (the Ministry) to develop and implement a quality and inspections framework for the delivery of fertility services across the province.
- Currently, only acts that use specified types of anesthesia or sedation are subject to inspection-assessment under the Out of Hospital Premises Inspection Program (OHPIP).
- In order to fulfill the Ministry's request, the College needs authority to enter and inspect the premises where fertility services are performed, regardless of whether anaesthesia or sedation is used.
- An amendment to *Ontario Regulation 114/94, Part XI (Inspection of premises where certain procedures are performed)* made under the *Medicine Act, 1991* is proposed to bring premises, including hospital-based fertility clinics which perform fertility services, under the OHPIP.
- The most significant changes being proposed to *Ontario Regulation 114/94* are:
    - Adding three additional procedures – in vitro fertilization (IVF), artificial insemination, and sperm cryopreservation and oocyte cryopreservation

– to the definition of procedure so that a premises performing any act in connection with the identified procedures would be subject to inspection-assessment under the OHPIP;
- Requiring premises to provide an inspector with requested information such as BORN[1] reports or data;
- Making hospital-based fertility clinics subject to inspection-assessment under the OHPIP.

- The drafting aims to strike a balance so that all fertility clinics will be subject to oversight, but other practice settings such as a family physician's office would not be inadvertently captured by the OHPIP.

- Council considered the draft regulation amendment at its September 2016 meeting and approved it for external consultation.

Assessment Related Costs

- The Out-of-Hospital Premises Inspection Program (OHPIP) is managed on a cost-recovery basis.

- Fertility clinics captured as part of the amendment to the regulation will be invoiced an annual fee estimated to be in the range of $3,895 to $4,490, billed to the Medical Director.

- The annual fee supports the core program infrastructure (administration and oversight of the inspection process) staffing and technology support, and the Premises Inspection Committee. Start-up costs associated with the development of the quality and inspections framework for fertility services will also be cost-recovered.

Development of the OHPIP Companion document

- The College's Expert Panel on Fertility Services is also in the process of finalizing a Companion document, "Applying the Out-of- Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises".

- The document is intended to be used in conjunction with the core OHPIP Standards and applies to fertility services offered in both OHPs and hospital-based clinics.

- The Companion document, and core OHPIP standards, will help fertility services practitioners plan for and participate in their inspection-assessments.

[1] The Better Outcomes Registry & Network (BORN) collects and interprets data about pregnancy, birth and childhood in the province. Since 2012, BORN has collected IVF data from Canadian fertility clinics.

The requirements in the documents will also be incorporated into the assessment criteria and tools use by College inspectors. These documents contain expectations in areas such as the use of gonadotropins for ovulation induction, general physical standards, and verification processes.

- In the coming months, Council will be provided with an update on the development of the Companion document and the process for commencing inspections of fertility services premises.

CURRENT STATUS:

- Council is provided with a report on the regulation consultation, as well as the revisions being proposed in response to the feedback received.

A. Report on Consultation

Consultation process

- Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire CPSO membership and key stakeholder organizations. In addition, a general notice was posted on the CPSO's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and *Patient Compass* (the College's public e-newsletter).

- Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, or by posting comments to a consultation-specific discussion page.

- The consultation was held between September 21 and November 25, 2016.

Number of responses

- The CPSO received a total of 23 consultation feedback responses: 18 (78%) were from physicians, 1 (4%) from a member of the public, and 4 (18%) from organizations[2].

- All written feedback received during the consultation is posted on the CPSO website in keeping with regular consultation processes and posting guidelines.

[2] Organizations who responded to the consultation were the following: Ontario Trial Lawyers Association (OTLA); Professional Association of Residents of Ontario (PARO); The Ministry of Health and Long-Term Care; The College of Physicians and Surgeons of Saskatchewan.

General comments

- The vast majority of respondents expressed support for the College's oversight of fertility services. Only one physician respondent expressed full opposition to the proposed regulation and the College's oversight of premises where fertility services are performed.

Support for the regulatory changes

- Of those respondents who supported the draft regulation, most offered a general statement of support.
- A number of respondents noted the vulnerability of patients and applauded increased oversight of fertility services.
- The Ontario Trial Lawyers Association stated that, "Ontarians availing themselves of the services provided by these clinics have always been – and will remain – especially vulnerable to abuse and exploitation."

Objections to the regulatory changes

- A number of physician respondents raised concerns that the College would be inspecting smaller fertility clinics that only provide intra-uterine insemination (IUI). A respondent argued, "IUI is just an easy office procedure (like a pap smear) that requires a lab tech and incubator. Surely the college does not want to audit every doctor's office that does pap smears!"
- The Ontario Trial Lawyers Association noted concerns with the College taking on this expanded role without a corresponding increase in resources.

Substantive comments

- Overall the majority of responses provided in this consultation were general in nature. Those that were substantive and/or included specific constructive suggestions are set out below.

Intra-uterine insemination

  - Two respondents, the Ministry and a physician felt that the act of intra-uterine insemination was too narrow for the regulation and suggested that it be broadened to "artificial insemination" or "intra-uterine or vaginal insemination".

Fertility Preservation

  - The Ministry proposed that the term "fertility preservation" be replaced by "sperm cryopreservation and oocyte cryopreservation" in order to clarify the acts involved.

- The Ministry also recommended that the phrase “for medical purposes” be removed in order to ensure that all services are captured under the inspection scheme, regardless of the reason they are rendered. This recommendation was also echoed by the Expert Panel in a meeting that occurred following the draft regulation’s release for consultation.

Gonadotropin Stimulation

- The Ministry suggested that gonadotropin stimulation for ovulation induction be specifically named in the regulation as part of the list of identified acts as it can be used in natural cycles, and not just for artificial insemination or IVF.

Performance and Data Reporting

- The Ontario Trial Lawyers Association recommended that performance and data reporting by clinics be made mandatory and be available to the public on the College’s website.

Impact on medical residents

- The Professional Association of Residents of Ontario (PARO) raised a number of questions about the impact of the regulatory framework on residents that rotate through fertility premises. PARO asked whether the College will require residents to identify themselves to the College if in training at a fertility services premises and asked what would happen to current or future residents in the event that a premises fails an inspection.

Counselling

- The Ontario Trial Lawyers Association questioned why counselling was not an included act in the regulation, stating that the “scope, caliber and quality of fertility counselling is of utmost concern to OTLA.”

B. Response to Feedback

- All of the feedback has been carefully reviewed and used to develop a revised draft regulation that can be found for Council’s information at **Appendix 1**.

<u>Prescribing of gonadotropins</u>

- Feedback had requested that the regulation include gonadotropin stimulation for ovulation induction as an identified procedure.

- The Expert Panel recognized the risks associated with the use of gonadotropins for ovulation induction and have therefore addressed this in

the Companion document that will be used in the inspection-assessments of fertility clinics under the OHPIP.

- The Companion document, developed by the College's Expert Panel on Fertility Services, and core OHPIP Standards, will help fertility services practitioners plan for and participate in their inspection-assessments. The Companion document addresses the use of gonadotropins for ovulation induction, stating that physicians should have the appropriate training and/or experience, including a plan to deal with potential complications. This requirement will be incorporated into the assessment criteria and tools used by College inspectors.

Revisions

1) In response to feedback, "intra-uterine insemination" has been changed to "artificial insemination" as this will capture a broader range of procedures.

2) "Fertility preservation for medical purposes" has been changed to "sperm cryopreservation and oocyte cryopreservation", in response to feedback received from both the Ministry and the College's Expert Panel. This change also removes reference to "for medical purposes" so that all acts of fertility preservation would be captured by the OHPIP.

Changes that were not made in response to the feedback

- Feedback from the consultation requested that performance and data reporting be made mandatory and that this information be available to the public. Although the College agrees that data reporting and availability is crucial, we are limited in our authority to compel data reporting to a third party such as BORN. Conversations with the Ministry about the further expansion of BORN's role in collecting data from facilities have begun. As well, the College's Expert Panel has communicated the need for collection and oversight of this data to the Ministry.

- The regulation excludes "the sole act of counselling or referral". Feedback had suggested that counselling services be included in the regulation. The objective of this exclusion is to ensure that a family doctor providing a patient with further information on fertility procedures, for example, would not be inadvertently captured as a premises under the revised regulation and therefore subject to an inspection-assessment under the OHPIP.

NEXT STEPS:

- Should Council approve the draft regulation, as revised, it will formally be submitted to government as a regulation amendment proposal.

NEXT STEPS CONT'D:

- Once government enacts the necessary changes to *Ontario Regulation 114/94, Part XI*, the College will have 24 months to complete inspections of all existing premises and will have 180 days to complete the inspections of any new premises that are not yet operational.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the revised draft regulation change proposal?

2. Does Council recommend that the revised draft regulation be approved for submission to government?

CONTACT: Wade Hillier Ext. 636
Shandelle Johnson Ext. 401
Nathan Roth Ext. 274
Miriam Barna Ext. 557

DATE: February 3, 2017

Attachments:

Appendix 1: Revised and tracked changes - Ontario Regulation 114/94, Part XI (Inspection of premises where certain procedures are performed) made under the Medicine Act, 1991

PART XI
INSPECTION OF PREMISES WHERE CERTAIN PROCEDURES ARE PERFORMED

44. (1) In this Part,

"inspector" means a person designated by the College to carry out an inspection under this Part on behalf of the College;

"premises" means any place where a member performs or may perform a procedure on a patient but does not include a health care facility governed by or funded under any of the following Acts:

1. The *Long-Term Care Homes Act, 2007*.
2. The *Developmental Services Act*.
3. The *Homes for Special Care Act*.
4. Revoked: O. Reg. 134/10, s. 1 (2).
5. Revoked: O. Reg. 192/14, s. 1.
6. The *Ministry of Community and Social Services Act*.
7. The *Ministry of Correctional Services Act*.
8. The *Ministry of Health and Long-Term Care Act*.
9. Revoked: O. Reg. 134/10, s. 1 (2).
10. The *Private Hospitals Act*.
11. The *Public Hospitals Act*;

"procedure" means,

(a) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed under the administration of,

(i) general anaesthesia,

(ii) parenteral sedation, or

(iii) regional anaesthesia, except for a digital nerve block, and

(b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to,

(i) any tumescent procedure involving the administration of dilute, local anaesthetic,

(ii) surgical alteration or excision of any lesions or tissue performed for cosmetic purposes,

(iii) injection or insertion of any permanent filler, autologous tissue, synthetic device, materials or substances for cosmetic purposes,

(iv) a nerve block solely for the treatment or management of chronic pain, or

(v) any act that, in the opinion of the College, is similar in nature to those set out in subclauses (i) to (iii) and that is performed for a cosmetic purpose,

(b.1) any act that is performed in connection with,

(i) in vitro fertilization,

(ii) artificial insemination and

(iii) sperm cryopreservation or oocyte cryopreservation,

but does not include,

(c) surgical alteration or excision of lesions or tissue for a clinical purpose, including for the purpose of examination, treatment or diagnosis of disease, ~~or~~

(d) minor dermatological procedures including without being limited to, the removal of skin tags, benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangioma and neurofibromata~~.~~, or O. Reg. 134/10, s. 1 (1, 2); O. Reg. 192/14, s. 1.

(e) the sole act of counseling or referral for the procedures set out in subsection (b.1).

(2) Anything that may be done by the College under this Part may be done by the Council or by a committee established under clause 94 (1) (i) of the Health Professions Procedural Code. O. Reg. 134/10, s. 1 (1).

(3) For the purposes of procedures included in subsection 44(1)(b.1) the definition of "premises" shall include a health care facility governed by or funded under The *Public Hospitals Act*.

45. (1) All premises where a procedure is or may be performed on a patient by a member in connection with his or her practice are subject to inspection by the College in accordance with this Part. O. Reg. 134/10, s. 1 (1).

(2) In carrying out an inspection of a premises under subsection (1), the College may also require any or all of the following:

1. Inspection, examination or tests regarding any equipment, instrument, materials or any other thing that may be used in the performance of a procedure.

2. Examination and copying of books, accounts, reports, records or similar documents that are, in the opinion of the College, relevant to the performance of a procedure in the practice of the member.

3. Inquiries or questions to be answered by the member that are relevant to the performance of a procedure on a patient.

4. Direct observation of a member in his or her practice, including direct observation by an inspector of the member performing a procedure on a patient. O. Reg. 134/10, s. 1 (1).

46. An inspector may, on the production of information identifying him or her as an inspector, enter and have access to any premises where a procedure is or may be performed by a member at reasonable times and may inspect the premises and do any of the things mentioned in subsection 45 (2) on behalf of the College. O. Reg. 134/10, s. 1 (1).

47. It is the duty of every member whose premises are subject to an inspection to,

(a) submit to an inspection of the premises where he or she performs or may perform a procedure on a patient in accordance with this Part;

(b) promptly answer a question or comply with a requirement of the inspector that is relevant to an inspection under this Part; and

(c) co-operate fully with the College and the inspector who is conducting an inspection of a premises, including collection and provision of information requested, in accordance with this Part. O. Reg. 134/10, s. 1 (1).

48. Where, as part of the inspection, an inspector directly observes a member in their practice, or directly observes the member performing a procedure on a patient, before the observation occurs, the inspector shall,

(a) identify himself or herself to the patient as an inspector appointed by the College;

(b) explain the purpose of the direct observation to the patient;

(c) inform the patient that information obtained from the direct observation, including personally identifiable information about the patient, may be used in proceedings under this Part or any other proceeding under the Act;

(d) answer any questions that the patient asks; and

(e) obtain the patient's written consent to the direct observation of the patient by the inspector. O. Reg. 134/10, s. 1 (1).

49. (1) No member shall commence using premises for the purposes of performing procedures unless the member has previously given notice in writing to the College in accordance with subsection (5) of the member's intention to do so and the premises pass an inspection or pass an inspection with conditions. O. Reg. 134/10, s. 1 (1).

(2) The College shall ensure that an inspection of the premises of a member referred to in subsection (1) is performed within 180 days from the day the College receives the member's notice. O. Reg. 134/10, s. 1 (1).

(3) A member whose practice includes the performance of a procedure on a patient in any premises on the day this Part comes into force shall give a notice in writing to the College in accordance with subsection (5) within 60 days from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(4) The College shall ensure that an inspection of the premises of a member referred to in subsection (3) is performed within 24 months from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(5) The notice required in subsections (1) and (3) shall include the following information, submitted in the form and manner required by the College:

1. The full name of the member giving the notice and the full name of the owner or occupier of the premises, if he or she is not the member who is required to give notice under this section.
2. The full name of any other member who is practising or may practise in the premises with the member giving the notice.
3. The name of any health profession corporation that is practising at the premises.
4. The full name of any hospital where the member or other members at the premises have privileges or where arrangements have been made to handle emergency situations involving patients.
5. The full name of any other regulated health professional who is practising or may practise in the premises with a member at the premises, along with the name of the College where the regulated health professional is a member.
6. The full address of the premises.
7. The date when the member first performed a procedure on a patient in the premises or the proposed date when the member or another member intends to perform a procedure on a patient at the premises.
8. A description of all procedures that are or may be performed by a member or other members at the premises and of procedures that may be delegated by the member or other members at the premises.
9. A description of any equipment or materials to be used in the performance of the procedures.
10. The full name of the individual or corporation who is the owner or occupier of the premises, if different from the member giving the notice.

11. Any other information the College requires that is relevant to an inspection conducted at the premises in accordance with this Part. O. Reg. 134/10, s. 1 (1).

49(6) All timelines and notice requirements provided in this section apply to every premises where a member performs or may perform a procedure listed in subsection 44(1)(b.1) with reference to the day that section 44(1)(b.1) comes into force.

50. All premises where a member performs or may perform a procedure on a patient are subject to an inspection by the College once every five years after its initial inspection or more often if, in the opinion of the College, it is necessary or advisable to do so. O. Reg. 134/10, s. 1 (1).

51. (1) After an inspection of a premises, the College shall determine, in accordance with the accepted standards of practice, whether the premises pass, pass with conditions, or fail. O. Reg. 134/10, s. 1 (1).

(2) In determining whether premises pass, pass with conditions or fail an inspection, the College may consider,

(a) the inspection results provided to the College by the inspector;

(b) information provided by one or more members who perform or may perform procedures in the premises respecting the inspection, including the answers given by them in response to inquiries or questions asked by the inspector;

(c) the information contained in a notice given by a member under subsection 49 (1) or (3);

(d) any submissions made by the member or members practising in the premises that are relevant to the inspection; and

(e) any other information that is directly relevant to the inspection of the premises conducted under this Part. O. Reg. 134/10, s. 1 (1).

(3) The College shall deliver a report, in writing, to the owner or occupier of the premises and to every member who performs or may perform a procedure on a patient in the premises, within a reasonable time after the inspection is completed, in accordance with section 39 of the *Regulated Health Professions Act, 1991*. O. Reg. 134/10, s. 1 (1).

(4) Any report made by the College respecting an inspection of premises where a procedure is or may be performed shall make a finding that the premises passed, passed with conditions, or failed the inspection and shall provide reasons where the premises passed with conditions or failed the inspection. O. Reg. 134/10, s. 1 (1).

(5) Any report made by the College that makes a finding that the premises failed an inspection or passed with conditions is effective on the day that it is received by one or more members who perform or may perform a procedure within the premises, in accordance with section 39 of the *Regulated Health Professions Act, 1991*. O. Reg. 134/10, s. 1 (1).

(6) A member shall not perform a procedure on a patient in premises that fail an inspection until,

(a) the College delivers a report indicating that the premises passed a subsequent inspection, or passed with conditions; or

(b) after considering submissions under subsection (8), the College substitutes a finding that the premises pass or pass with conditions. O. Reg. 134/10, s. 1 (1).

(7) A member shall not perform a procedure on a patient in premises that pass an inspection with conditions except in accordance with the conditions set out in the report until,

(a) the College delivers a report indicating that the premises passed a subsequent inspection; or

(b) after considering submissions under subsection (8), the College substitutes a finding that the premises pass. O. Reg. 134/10, s. 1 (1).

(8) A member may make submissions in writing to the College within 14 days from the day he or she receives a report made by the College that finds that the premises passed with conditions or failed the inspection. O. Reg. 134/10, s. 1 (1).

(9) The College may or may not elect to re-inspect the premises after receiving a member's submissions, but no more than 60 days after a member provides his or her submissions, the College shall do one or more of the following:

1. Confirm its finding that the premises failed the inspection or passed with conditions.

2. Make a report and find that the premises pass with conditions.

3. Make a report and find that the premises passed the inspection. O. Reg. 134/10, s. 1 (1).

(10) Premises that fail an inspection or pass with conditions may be subject to one or more further inspections within a reasonable time after the College delivers its report, at the request of a member, any other person to whom the College gave the report, or at any time at the discretion of the College. O. Reg. 134/10, s. 1 (1).

(11) Where, as a result of an inspection carried out under this Part, a report made by the College finds that a member's knowledge, skill or judgment is unsatisfactory, the College may direct the Registrar to refer the report to the Quality Assurance Committee. O. Reg. 134/10, s. 1 (1).

(12) Where, as a result of an inspection carried out under this Part, a report made by the College finds that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the College may direct the Registrar to refer the report to the Inquiries, Complaints and Reports Committee. O. Reg. 134/10, s. 1 (1).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: Proposed Fee Increases – Consultation Report

DATE: February 1, 2017

For Decision

ISSUE:

- The College sought feedback on draft amendments to the Fees and Remuneration By-Law that, if passed, would increase several fees at the College, including the annual membership fee for the year beginning June 1, 2017.

- At its December meeting, after reviewing the proposed budget for 2017, Council proposed a 1.88% increase in membership fees. The increase would bring the fee that a physician pays to renew a certificate of registration from $1,595 to $1,625.

- Council also proposed increasing the Certificate of Professional Conduct fee from $50 to $75 (this fee has not been increased since 2008), increasing the fee for an application for a certificate of registration for a post-graduate license from 10% of the membership fee to 25%, and increasing the fee for an application for a certificate of registration for an independent practice from 50% of the membership fee to 60%.

- Council also proposed establishing an expedited review service fee for those registration applications that meet the regulation. Applicants who wish to expedite the initial assessment of such applications to less than three weeks will have the option to do so with the new fee.

- A number of channels were used to garner participation in this consultation, including:
    - An article in Vol. 12, issue 4 of Dialogue;
    - An e-mail to the OMA;
    - Various calls to participate through our three social media properties (Twitter, Facebook, and LinkedIn);
    - A posting in the consultation section of the CPSO website; and
    - A notice in the Council Update e-newsletter.

- Stakeholders were able to submit their feedback via:
    - E-mail
    - An online feedback form
    - Regular mail or fax

BACKGROUND:

- At the annual budget meeting of the Finance Committee on October 11, 2016, the Finance Committee recommended to Council several fee increases related to Application Fees and Certificates of Professional Conduct. The changes to the application fees and certificates of professional conduct required circulation to the membership. The Finance Committee determined that these increase were necessary to meet the growing demands of the College.

CURRENT STATUS:

A. Report on Consultation

Consultation process

- Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire CPSO membership. In addition, a general notice was posted on the CPSO's website, Facebook page, and announced via Twitter. It was also published in *Dialogue.*

- A consultation specific page was created, giving stakeholders the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to an online discussion page.

- The consultation was held between December 7, 2016 and February 10, 2017.

Number of responses

- At the time of drafting these briefing materials, the CPSO received a total of 136 consultation feedback responses on the consultation specific discussion page. 100 physicians, 1 organization and 25 anonymous submissions were received.

- 125 comments were submitted via the online forum and 11 were submitted via email.

Feedback

- All written feedback received during the consultation is posted on the CPSO website in keeping with regular consultation processes and posting guidelines.

General Comments

- Broadly speaking, the nature and tone of the feedback received in response to the proposed by-law amendments to increase fees was negative.
- All but four comments from stakeholders were strongly opposed to the fee increase.
- The four comments in favour of the fee increase recognized the need for it and commented that the increases were "modest" in size.

- The vast majority of negative comments targeted the optics of the fee increase in light of the uncertainty surrounding the current negotiations between Physicians and the Ontario government. They also commented on the futility of commenting since the CPSO raised fees last year, despite receiving almost 600 negative comments.
- Many commenters suggested that the CPSO audit its financial records and search for areas to reduce spending. One such area frequently suggested was to vacate the downtown Toronto office and move to an economically-favourable location.

Organization Feedback

- The only organization to provide feedback, PARO (Professional Association of Residents of Ontario), felt that the fee increase for postgraduate trainees was disproportionate to the other fee increases. PARO also argues the disproportionate increase in fees compared to other membership classes is undue hardship in light of additional training expenses, high costs of tuition and other various fees required of Residents.

DECISION FOR COUNCIL:

Does Council approve the recommend fee increases?

Contact:

Leslee Frampton, ext. 311
Douglas Anderson, ext. 607
Nawaz Pirani, ext. 765

Date: February 1, 2017

TOUCHSTONE

INSTITUTE

COMPETENCY EVALUATION EXPERTS

A Practice Ready Assessment Program for Family Medicine College of Physicians And Surgeons of Ontario (CPSO) Council

Sten Ardal

February 24, 2017

Ontario PRA Program

- Adheres to NAC PRA Standards
- Phased-in approach with a two-year commitment (20 candidates)
- Program administrator – Touchstone Institute
- Provides an alternative route to practice for FM IMGs
- Physician distribution to communities in high need
- HFO MRA & LHINs to identify Eligible Communities/Organizations for Return of Service period (managed via MOHLTC)

NAC PRA Family Medicine Standards

- MCC has initiated a pan-Canadian PRA program that is consistent and comparable across provinces and territories
- Several provinces already offer PRA:
  - Practice Ready Assessment – Physicians for BC (PRA-BC)
  - Alberta Provincial Physician Assessment Program (PPAP)
  - Saskatchewan International Physician Practice Assessment (SIPPA)
  - University of Manitoba International Medical Graduate Program
  - Collège des médecins du Québec
  - Clinical Skills Assessment and Training in Newfoundland and Labrador

PRA Process Overview

TOUCHSTONE INSTITUTE
COMPETENCY EVALUATION EXPERTS

Consultations to Date

- Submitted Program Proposal to MOHLTC
- Presented to:
  - CPSO Registration Committee
  - PG COFM
  - FM Program Directors
  - Office of the Fairness Commissioner
- Informal discussions with other PRA Programs, the MCC, PhysiciansApply.ca, CPSO, HFO MRA and other stakeholders

Expert Informed Process

- Informed by previous consultation and research conducted by the MOHLTC (subject to change based on additional review and validation)

- Currently being validated by the Program's **Clinical Expert Group** that provides leadership on selection and assessment procedures
  - **Dr. Marcus Law**
  - **Dr. Alan Monavvari**
  - **Dr. Daniel Way**
  - **Dr. Inge Schabort**
  - **Dr. John Stewart**

- Operational leadership is provided by a **Working Group** with representation from HFO MRA, CPSO, MOHLTC and Touchstone Institute

Candidate Eligibility

Immigration Requirement: Permanent Resident Status or Canadian Citizen
Medical Education: Acceptable Medical Degree (according to CPSO Policy)
English Language Proficiency: Minimum IELTS score
Examinations: MCCEE, MCCQE1, MCCQE2 & NAC OSCE
Post-Graduate Training: Two years of training in family medicine/general practice leading to registration/recognition as a family physician/general practitioner in that jurisdiction including: • Rotations of four weeks (full-time) in emergency medicine, general surgery, internal medicine, ob-gyn, pediatrics, psychiatry; and • Rotation of eight weeks (full-time) in family medicine/general practice
Independent Practice: Evidence of active, independent practice as a family physician/general practitioner in another jurisdiction for a minimum of three consecutive years.
Currency of Practice: Minimum of 24 weeks (or 960 hours) or clinical practice as family physician/general practitioner in the immediately preceding three years.
Other: Criminal Record Check, Proof of Professional Conduct, Academic Credential Verification, No existing ROS, has not exceeded maximum attempts of PRA in other programs

Candidate Selection & Orientation

Selection:

- Informed by eligibility criteria
- NAC OSCE - cut score for PRA selection purposes
- Therapeutics Decision Making Examination
- Additional customized assessment of non-medical expert competencies being developed

Orientation:

- Follows National PRA Standards
- Leverages Touchstone Institute's experience delivering orientation programming for IMGs
- Added programming for PRA planned for Fall 2017

12-Week Clinical Field Assessment

- Assessment period not training (resulting in a P/F decision)
- *Not* Most Responsible Physician – supervised practice setting (ongoing & closely supervised with sufficient time and structure)
- PRA Model includes multiple independent observations made across multiple situations by multiple observers
- Following recommendations for assessment documentation as per National PRA Standards

12-Week Clinical Field Assessment cont'd

Assessment Model:

- Recruitment of assessors and appropriate assessment sites led by Touchstone Institute
- Assessors to be approved by CPSO
- Comprehensive assessor training using NAC PRA training program
- Assessment to occur in a like community to that which the candidate will complete their Return of Service commitment

Appeals

- A review and independent appeals process is being developed

TOUCHSTONE
INSTITUTE
COMPETENCY EVALUATION EXPERTS

Questions?

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **PRACTICE READY ASSESSMENTS IN ONTARIO (PRA)**

DATE: **FEBRUARY 24, 2017**

FOR DECISION

ISSUE:

- The Ministry of Health and Long Term Care has requested the creation of a PRA program for family medicine to launch in 2017 with a small number of eligible candidates. A PRA Program is designed to identify international medical graduate candidates who are deemed ready to enter practice in Ontario based on meeting qualification requirements and successfully completing a 12-week clinical assessment.
- The Medical Council of Canada has developed, with the active involvement of medical regulators in Canada, standards for PRA Programs operating in multiple provinces. There is an existing competency framework for evaluating Family Medicine within the pan-Canadian standards, developed by the College of Family Physicians of Canada.
- Ontario's PRA program has been developed with extensive involvement by the CPSO and Touchstone, and it aligns with the national standards.
- Council is asked to approve recommendations from the Registration Committee and Executive regarding the Certificates of Registration that will be issued to facilitate the clinical assessment stage of PRA and the first certificate of registration to practice following successful completion of the assessment.
- The CFPC has also made a policy change to facilitate the CPSO registration of PRA candidates.

BACKGROUND:

- This item was first presented to the Executive Committee at its meeting in November 2016.
- At that time, the Registration Committee had proposed:
    - A "PEAP" (pre entry assessment period) certificate of registration to facilitate the 12 week PRA clinical assessment stage and,
    - Following successful completion of the clinical assessment, a restricted certificate of registration to practice medicine under supervision for 42 months **or** until such time that the candidate successfully achieves certification by the CFPC by completing the examination.

- The Executive Committee expressed concern that the CFPC had not yet met to consider the PRA program and whether it could fit within CFPC's existing policies. The Executive Committee also sought reassurance that the Registration Committee had met face to face to discuss the amendment to the certificate accordingly.

- Since 2008 the "CPSO" has had two routes/policies outside of the traditional routes to licensure of Canadian residency, Canadian Medical Council Exams and CFPC certification:

  Route 1 (Pathways):
  Where a board certified family physician practising independently in the United States came to practice in Ontario under supervision, never wrote the CFPC exam, but after 18 months of supervision underwent a registration assessment to confer specialty,

  -or-

  Route 2 (Exam Eligible):
  Where a family physician coming to us from a recognized jurisdiction was deemed exam eligible by CFPC, after having completed 2 years of Canadian practice experience under supervision, could then attempt the CFPC exam "Exam Eligible"

- At the time of the Executive Council meeting, the CFPC required 2 years of Canadian practice experience, facilitated most often under supervision, to be eligible to write its certification examination

- The dilemma remained that the PRA candidates did not fit perfectly within either existing College policy

- Without CFPC deeming the candidate exam eligible in Route 2, a PRA candidate would need 2 years of licensure approved first by the College to then apply for exam eligibility.

- The impact then would be that these candidates would need possibly 5 years of supervised practice; 2 years to achieve exam eligibility and an additional 3 years under the College's existing policy to write the exam.

- Executive Committee was concerned with making a recommendation to accept the proposed licensing scheme with the possibility of CFPC not changing its program, and deferred for the appropriate meetings to occur.

CURRENT STATUS:

- Since the November Executive Committee meeting senior staff of both the College and CFPC has worked together to put forward a proposal to the CFPC's Board of examiners.

CURRENT STATUS CONT'D:

- Registration Committee has now been advised that the CFPC Board of Examiners have met, and its decision was to make changes to their eligibility requirements in support of PRA candidates as follows:

  The CFPC Board of Examiners - have determined that it will grant a 1-year reduction of the required 2 years of Canadian practice experience if a candidate successfully completes a PRA program that is able to demonstrate that it fully meets the following NAC-PRA standards regarding assessment and that it uses CFPC or CMQ certified assessors where possible:

  - Competencies & Context of Assessments
  - Over Time Assessment Environment
  - Assessment Period
  - Assessor Recruitment & Supports
  - Over Time Assessment Tools
  - Decision Making - A formal decision making process is documented & transparent to the PRA candidate & PRA programs

  For details please refer to Appendix A.

- At its meeting on January 17th, the Executive Committee approved Registration Committee's recommendation that the PEAP Certificate of Registration for the PRA period and a subsequent restricted certificate of practice under supervision for twenty four months be issued for participants in this program.

RECOMMENDATION:

- The PRA period will be for a period of 12 weeks with the purpose of the candidate physician practicing under the MRA approved assessor to be assessed; this time frame would be appropriately matched by a restricted certificate that would mimic the College's existing PEAP certificate (Pre Entry Assessment Period) currently used for educational screening of IMG residents.

- The Certificate of Registration is for the purpose of assessment only, and the individual will function under close supervision with ongoing evaluation. For the proposed terms, conditions and limitations of the assessment period please refer to Appendix B.

- After a candidate is deemed successful (the assessment developed to review and adjudicate whether a candidate has met the family medicine competencies or not), the recommendation by the Clinical Expert Group of family physicians set-up specifically for the purposes of this program (under the auspices of Touchstone) would come back to the Registration Committee with the supervision agreement

from the host community and proposed practice plan (work details) for the candidate under supervision for consideration and approval.

- These candidates will have gone though the most vigorous selection process by having successfully completed:

    - An IP certificate and practice in their home jurisdiction
    - The Medical Council of Canada Evaluating Exam
    - The Medical Council of Canada Qualifying Exam, Part One and Two
    - The NAC-Examination
    - The Therapeutics Exam
    - Successful Completion of the PRA

- After successfully completing all of the above, the Registration Committee would review additional candidate information from the application process and determine if it will issue a restricted certificate.

- To meet the eligibility requirements of the CFPC, successful candidates will practice under supervision for a period of 12 months – during which they will not have access to sit the certification examination.

- To coordinate the CPSO's policies and practices with the CFPC policy changes, it is proposed that the duration of the restricted certificate be for a total period of no more than 24 months. This first 12 months of the certificate will serve to satisfy the CFPCs eligibility requirement for the examination – the second 12 months of the certificate will allow candidates to attempt the CFPC examination.

- As a further safety mechanism, there will be an automatic and immediate expiry of the CPSO restricted certificate of registration on a candidate's first unsuccessful attempt at the CFPC certification exam[1].

- For the proposed terms, conditions and limitations of the Certificate Please refer to Appendix C.

- A successful PRA candidate would then be issued a scope defined IP limited to Family Medicine.

[1] An unsuccessful CFPC examination attempt is always possible, but the qualification of such candidates will be sufficiently high to reduce this possibility.

DECISION FOR COUNCIL:

Council is asked to approve the Executive and Registration Committee's recommendation that the PEAP Certificate of Registration for the PRA period and a subsequent restricted certificate of practice under supervision for twenty four months be issued for participants in this program.

CONTACT: Nathalie Novak, Manager Applications and Credentials x 432
Wade Hillier, Director Quality Management Division x 636
Carolyn Silver, Senior Legal Counsel x 239

DATE: January 30, 2017

Appendices:

Appendix A: Letter from the CFPC
Appendix B: Proposed Terms, Conditions and Limitations to the PRA PEAP
Appendix C: Proposed Terms, Conditions and Limitations for the practice phase of the PRA certificate

APPENDIX - A

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

December 13, 2016

Nathalie Novak
Manager, Applications and Credentials
The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario M5G 2E2

Dear Ms. Novak,

Re: Practicing Physician Eligibility Criteria for CFPC Certification Examination in Family Medicine and Practice Ready Assessment Programs

As requested, at its most recent meeting in early December, the CFPC's Board of Examiners reviewed the practicing physician eligibility criteria for the Certification Examination in Family Medicine as they apply to candidates who complete a Practice Ready Assessment (PRA) Program.

The outcome of the review is that the Board of Examiners will grant a 1-year reduction of the required 2 years of Canadian practice experience if a candidate successfully completes a PRA program that is able to demonstrate that it fully meets the following NAC-PRA standards regarding assessment and use CFPC or CMQ certified assessors where possible:

- Competencies & Context of Assessments
- Over Time Assessment Environment
- Assessment Period
- Assessor Recruitment & Supports
- Over Time Assessment Tools
- Decision Making - A formal decision making process is documented & transparent to the PRA candidate & PRA programs

This means that any successful PRA candidate (while meeting other eligibility requirements) from a PRA program that fully meets the above standards will be eligible to sit the Certification Examination in Family Medicine if he/she has completed a total of 4 years of practice experience, whereby 1 of these 4 years was full-time active practice in Canada. The other 3 years of practice experience can be outside of Canada and the CFPC gives 1 year of credit towards each year of relevant postgraduate training (assuming training not accredited by CFPC or ACGME) for up to a maximum of 2 years. (Please note that this Canadian practice requirement does not apply to graduates of medical schools accredited by the Liaison Committee on Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools (CACMS) or Graduates of schools of osteopathic medicine accredited by the Bureau of Professional Education of the American Osteopathic Association).

Details of current practicing physician eligibility criteria are here: http://www.cfpc.ca/Category A/ and http://www.cfpc.ca/CategoryB/.

In arriving at this decision, the Board of Examiners considered the following factors:

- PRA, if meeting NAC-PRA standards, can be a high-quality assessment in determining competence for a provisional licensure for supervised practice, especially since it is conducted in a Canadian context that will be similar to one that the successful PRA candidate will be conducting supervised practice. It is reasonable that a successful PRA may be seen as comparable to some time spent in Canadian practice in terms of eligibility for our Certification Examination
- Given that validity of any assessment increases with the duration of the assessment, the PRA, being 12 weeks in duration, will have its limitations. It was felt that some time in supervised practice under a provisional license after successful completion of a PRA will be invaluable in ensuring that performance during a PRA translate into the practice environment where the candidate has a greater level of autonomy and responsibility.
- From a validity perspective for our Certification Examination, a period of time in supervised practice is desirable because this time will minimize construct irrelevance and allow the Examination to better test the competencies it intends to test. The successful PRA candidates will have more adequate amount of time to
    a) fully adjust to the Canadian practice environment,
    b) learn about the format of our examination, and
    c) prepare for our Certification Examination.
- Despite having a program evaluation for PRA, this program evaluation is voluntary in nature and may not ensure that all PRA programs uniformly meet NAC-PRA standards. As such, the Board of Examiners will need to be satisfied that a particular PRA program is meeting NAC-PRA standards, especially standards pertaining to the rigor of assessment, before it will consider reducing the amount of time required in Canadian practice as an eligibility requirement for the Certification Examination in lieu of a successful PRA.

In the near future, I will be working with my staff, with input from the PRA programs, to collaboratively develop a process whereby a PRA program can demonstrate to the CFPC that it is meeting the relevant NAC-PRA standards such that its successful candidates may receive a reduction of the eligibility requirement to sit our Certification Exam from 2 years of full-time Canadian practice experience to 1 year.

Additional communication regarding this decision will be forthcoming to all medical regulatory authorities and PRA programs.

Sincerely,

Eric Wong MD MClSc(FM) CCFP FCFP
Director, Certification and Examinations / Directeur, Certification et Examens
Academic Family Medicine/ Médecine familiale universitaire

cc: Dan Faulkner, Deputy Registrar, CPSO
David Ross, Chair, CFPC Board of Examiners

Appendix B:

Terms and conditions for physicians entering the assessment phase of the PRA program:

(1) Dr. FULL NAME may practise medicine only:

a) In a Practice Ready Assessment Program to which the holder is appointed;
b) To the extend required to complete the Practice Ready Assessment Program to which the holder is appointed; and
c) Under a level of supervision that is determined to be appropriate for the holder of the program of medical education and assessment, by a member of the College of Physicians and Surgeons of Ontario designated by the director of the program.

(2) Dr. FULL NAME may not charge a fee for medical services.

(3) This certificate expires when Dr. LAST NAME is no longer enrolled in the Practice Ready Assessment Program specified in paragraph (1), which may be no more than twelve weeks in duration.

Note: This certificate is issued on DATE and expires EXPIRY (12 weeks from issuance), or when Dr. LAST NAME's enrolment in the Practice Ready Assessment Program ends, whichever occurs first.

Appendix C:

Terms and Conditions for Physicians Entering the Practice Phase of the PRA Program:

1. Dr. FULL NAME may practice family medicine at LOCATION in CITY, Ontario, while under supervision coordinated by a supervisor acceptable to the College.

2. The certificate of registration automatically expires after one unsuccessful attempt at the College of Family Physicians of Canada certification examination or twenty four months from the date of issuance, **whichever comes first.**

3. The certificate of registration automatically expires upon the following events, unless the Registration Committee renews the certificate with or without additional or other terms, conditions and limitations:

   (i) the supervisor notifies the College of any concerns regarding Dr. NAME's knowledge, skill, judgment or attitude, does not provide the required reports to the College by the due date or if the reports are unsatisfactory in form or content, or

   (ii) the supervisor is no longer able or willing to continue to supervise Dr. NAME's practice.

<u>Pre-conditions:</u>

Dr. NAME will agree to the terms, conditions and limitations outlined in the Undertaking document, and which includes but not limited to:

- to practice under the supervision of Dr. SUPERVISOR;
- Take the College of Family Physicians of Canada certification examination, each time it is available to him/her during the term of this certificate, until such time that he/she is successful in the examination,

  The terms, conditions and limitations outlined in the Undertaking document.

The supervising physician will agree to the terms, conditions and limitations outlined in the document undertaking of the supervising physician and which includes, but not limited to:

- Provide supervision of Dr. NAME's practice;
- Submit reports to the College every six months.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: COUNCIL AWARD

DATE: FEBRUARY 24, 2017

FOR INFORMATION

ISSUE:

At the February 24th meeting of Council, **Dr. Shazia Ambreen** of Alliston, Ontario will receive the Council Award.

BACKGROUND:

The Council Award honours Ontario physicians who have demonstrated excellence based on eight "physician roles".

- The physician as medical expert / clinical decision maker
- The physician as communicator
- The physician as collaborator
- The physician as gatekeeper / resource manager
- The physician as health advocate
- The physician as learner
- The physician as scientist / scholar
- The physician as person and professional

CURRENT STATUS:

Council member Dr. Carol Leet will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402

Date: February 3, 2017

Appendices: N/A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN CAMERA

February 2017

COUNCIL BRIEFING NOTE

TOPIC: Bill 87 – Amendments to the RHPA: Overview and Analysis

FOR DECISION

ISSUE:

- On December 8, 2016, Bill 87, the *Protecting Patients Act, 2016* was introduced. The Bill is an omnibus health bill that contains the government's response to the recommendations made by the Minister's Sexual Abuse Task Force (SATF). Schedule 4 of the Bill sets out the amendments to the *Regulated Health Professions Act* (RHPA).

- This briefing note material provides Council with an overview and analysis of Schedule 4 of the Bill.

- The objective is to provide government with the College's response as soon as possible and to participate fully in the legislative process as the Bill moves forward. Council's feedback on the analysis and the issues identified will inform the College's response and ongoing involvement in the legislative process.

- This briefing note is organized as follows:
  A. Background
  B. Bill 87: Overview
  C. Analysis
  D. Additional legislative change proposals
  E. Next Steps

A. BACKGROUND

- The Minister of Health and Long-Term Care appointed the Task Force on the Prevention of Sexual Abuse of Patients and the RHPA (SATF) in December 2014.

- The SATF submitted a report entitled *To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act.*

- The 34 recommendations from the task force were released on September 9, 2016 and focus on six key areas:

- Empowering patients in the health regulatory system
- Strengthening requirements under the RHPA
- Strengthening leadership and accountability
- Increasing transparency throughout the health regulatory sector
- Improving the complaints, investigation and discipline processes for sexual abuse cases
- Enhancing knowledge and education

- On the day the SATF recommendations were released, the Minister of Health and Long-Term Care put out a public statement identifying the action government plans to take to prevent sexual abuse of patients.

- As Council will note, the Ministry's statement speaks to its intention to release legislative amendments to the RHPA, which would respond to the SATF recommendations. They include proposed amendments to:

  - Strengthen sexual abuse provisions
  - Increase transparency of health regulatory colleges' operations
  - Improve the colleges' complaints, investigation and discipline processes.

- These legislative amendments have been included in Bill 87.

- The Ministry has also committed to consulting and engaging with system partners on the remaining recommendations.

- The College response to the introduction of the Bill 87 is contained in a December 8 news release. The College will fully participate in the legislative process to help ensure that the regulatory system has the tools needed to ensure patient protection.

B. BILL 87: AN OVERVIEW

- Bill 87 (the *Protecting Patients Act*, 2016) is an omnibus bill containing five schedules and amends several pieces of legislation, including the RHPA (schedule 4). Other schedules amend *the Immunization of School Pupils Act, the Laboratory and Specimen Collection Centre Licensing Act, the Ontario Drug Benefit Act,* and *the Senior Active Living Centres Act*. It was introduced on December 8, 2016.

- The changes proposed with respect to the RHPA are significant and go well beyond addressing issues pertaining to sexual abuse. It is an important Bill for the College. The Bill also includes the government's legislative approach to transparency as well as its response to the review conducted by the Hon. Stephen Goudge, *Streamlining the Physician Complaints Process in Ontario*.

- Below, major elements of Bill 87 relating to the RHPA have been summarized in plain language for Council's reference and convenience.

INCREASED MINISTERIAL POWERS

- The Bill contains a number of new powers for the Minister of Health. Two are highlighted here. The additional ministerial regulation-making powers are noted throughout this brief where appropriate.

- *Section 5: Reports and Information to the Minister*: The Bill contains an amendment to the existing section 5 of the RHPA. The proposed amendment would permit the Minister to compel regulatory Colleges to provide reports and information to the Minister. The reports are intended to allow the Minister to determine whether the College is fulfilling its duties or whether the Minister should exercise his or her ministerial powers under the RHPA. It is important to note that such reports and information could contain personal information and personal health information about a member.

- *College Committee and Governance*: The Bill contains provisions that would allow the Minister to develop regulations relating to all aspects of the structure of statutory committees. This includes:
    a. Composition of committees;
    b. Qualifications, selection, appointment and terms of the members of those committees;
    c. The disqualification and removal of those committee members;
    d. Composition of panels selected from members of the Registration Committee, ICRC, Discipline Committee and Fitness to Practise Committee and identifying the number of panel members that would constitute quorum.

- Once such regulations are in place, existing quorum provisions in the RHPA (e.g. Discipline Committee panels) would no longer be in place. These regulations would also supersede existing College bylaw provisions.

SEXUAL ABUSE

- The Bill contains a number of provisions related to sexual abuse. The most significant changes are highlighted below.

a) College Processes, Functions and Duties

- Bill 87 allows the Minister to develop regulations specifying how Colleges are to perform its functions dealing with complaints, reports, discipline and incapacity matters when the matter involves misconduct of a sexual nature. The Minister would also be able to set out additional functions and duties for the College.

- These provisions appear to have been included in Bill 87 to address a recommendation by the SATF to improve colleges' complaints, investigations and discipline processes pertaining to sexual abuse and to ensure consistency in

processes amongst the health Colleges. The Minister has indicated that an expert advisor will be appointed to assist with this work.

- The College has expressed its willingness to cooperate with an Expert Advisor who will reportedly be charged with gathering information on College processes and making recommendations on how Colleges should perform its functions in the areas identified above.

b) Mandatory Revocation

- Bill 87 expands the list of acts of sexual abuse specified in the Code that will result in mandatory revocation. The added acts that will result in mandatory revocation include: touching of the patient's genitals, anus, breasts or buttocks (subject to the clinically appropriate exception). These acts will be subject to the corresponding inability to apply for reinstatement for at least five years.

- The Bill specifies that mandatory revocation will be imposed in an additional instance: where a member has been found guilty of professional misconduct by a health profession regulator outside of Ontario and the professional misconduct relates to a sexual act that has been specified as resulting in mandatory revocation.

- The Bill contains provisions that would enable the list of acts resulting in mandatory revocation to be augmented in the future through regulation. If enacted, the Bill would enable the Minister to make regulations,
    - Specifying further acts of sexual abuse that will result in mandatory revocation.
    - Designating certain offences (e.g. sexual assault or others) as also resulting in mandatory revocation.

c) Definition of Patient for Sexual Abuse Purposes

- The Bill sets out a new definition of the term 'patient'. 'Patient' is defined to include someone who was a member's patient within the last year.
    - The Bill makes it clear that this definition is limited to the sexual abuse provisions of the Code.
    - The definition has the effect of setting out a minimum period (of one year) before regulated health professionals can have a sexual relationship with such individuals.

- The Bill includes a new regulation-making power related to this definition, which would enable individual Colleges to make regulations setting out a longer period of time that must pass before a member can engage in a sexual relationship with a former patient.

- The Bill also provides the Minister with the authority to make regulations establishing additional criteria that would be used to determine who is a patient for the purposes of the sexual abuse provisions of the Code.

d) Orders in Sexual Abuse Cases

- The Bill includes a provision that would prevent a panel of the Discipline Committee of Colleges from ordering gender-based restrictions. This provision would prevent gender-based restrictions from being made in all cases, including sexual abuse cases.

- Provisions in the Bill also specify that when a panel of the Discipline Committee makes a finding of sexual abuse that requires mandatory revocation and the penalty portion of the hearing is deferred, the panel must immediately suspend the member's certificate of registration until the mandatory revocation is ordered.

- The Bill further specifies that where a finding of sexual abuse is made and mandatory revocation is not ordered, there must be at least some suspension ordered.

- The Bill strengthens the authority for ICRC panels to impose interim orders (including suspensions) prior to a referral to discipline under certain conditions. Interim orders cannot include gender-based restrictions.

e) Patient Relations Program

- Changes have been proposed to the funding for therapy and counselling program, which forms part of the Patient Relations Program, administered by the College's Patient Relations Committee.

- The Bill alters the criteria that specify when an individual is eligible for funding under the Program. It repeals specific criterion for eligibility and instead states that funding will be available to an individual who makes a complaint or is the subject of a mandatory report alleging sexual abuse.

- The Bill includes new regulation-making authority for the Minister. This authority would enable the Minister to expand the types of expenses for which funding must be provided. Currently, funding can only be used to cover the costs of therapy or counselling. Through regulation, the Minister could enable funding to be used for related expenses such as costs of medication, or child care should that be required for the individual to access therapy.

- The regulation-making authority would also enable the Minister to set out in regulation new functions for Colleges' Patient Relations Programs.

f) Mandatory Reports for Sexual Abuse

- The Bill includes amendments that would increase fines for those who have failed to make a mandatory report regarding sexual abuse.

TRANSPARENCY

- The Bill includes a number of amendments related to transparency.

- It expands the list of content that must be included on Colleges' public registers. The new mandatory content includes: the date a former member died, oral (but not written) cautions, SCERPs, the date and status of referrals to discipline, a copy of the specified allegations, a synopsis of disciplinary and incapacity decisions even where no finding was made, acknowledgements and undertakings, and any inspection outcomes.

- A new ministerial regulation-making power has been proposed, which would enable the Minister to expand, through regulation, the list of information Colleges must include on the public register.

- The Bill specifies that the Registrar has an explicit duty to post all information promptly.

- The Bill also requires the Registrar to correct any information where a member demonstrates to the satisfaction of the Registrar that the information is incomplete or inaccurate.

- Under the Bill, Colleges will also be required to post information about Council meetings on the College's website.

OTHER CHANGES

- A number of additional provisions have been included in the Bill that are relevant to the College.

- *Alternative Dispute Resolution:* The Bill includes amendments to the provisions concerning alternative dispute resolution (ADR). These amendments would allow the Registrar to approve a resolution reached through ADR or to require that a matter be sent to ICRC. Under a pre-existing provision in the Code, (s. 25.1(2)), all information/communication from the ADR process shall remain confidential.

- *Withdrawal of Complaints:* The Bill allows the Registrar to withdraw a complaint at the request of the complainant. The Registrar would not be obliged to withdraw the complaint however, if it was not in the public interest to do so.

- *Members' Information:* The Bill amends section 36.1 of the RHPA to enable the Minister to require a College to collect information from members for the purposes of health human resources planning or research.

C. ANALYSIS

- Throughout its Sexual Abuse Initiative and its efforts to support the SATF, the College has expressed its commitment to protect patients from sexual abuse by physicians, to review and improve our processes and practices, and to ensure patients have the support and information they need.

- Over the past several years, the College has advanced a number of recommendations for legislative change to help strengthen the existing legislative framework, particularly as it pertains to protecting patients from sexual abuse. The College has also advocated for legislative change to ensure the effectiveness and integrity of College processes.

- These commitments and the College's work to date have directly informed this analysis of Bill 87.

- The Bill incorporates several legislative change proposals that the College has advanced (including as part of Council's work on its Sexual Abuse Initiative). In some cases, the provisions, as they have been captured in the Bill require minor amendments that we would characterize as "housekeeping" to achieve the intended objective.

- In other cases, we are supportive of the government's objective but have concern with the method used to achieve the objective. For example, we believe that College investigative processes should be dealt with in policy as opposed to regulation so that necessary improvements can be made in a timely way. We believe that important functions, such as the functions of statutory committees should be contained in the statute where they are established and modified by the Ontario legislature.

- In summary, the College supports the intent and the overall objectives contained in Bill 87. The analysis and recommendations that follow are meant to inform the development of College submissions on the Bill and subsequent amendments to ensure patient protection and the effectiveness of our regulatory processes.

- The content below is grouped in two sections: Substantive Issues, and Housekeeping or Drafting Issues.

SUBSTANTIVE ISSUES

1. **The proposed amendments significantly amend (yet restrict) the criteria to access the Patient Relations Program's fund for counselling and therapy.**

Analysis:

- The proposed amendments appear to have a paradoxical impact:
    - In one sense it expands eligibility beyond the current approach, essentially granting automatic access to funding to any individual who is named in a complaint or mandatory report regarding sexual abuse, even those who are not pursuing therapy.
    - Conversely, the language is restrictive: it would prevent those individuals who have been sexually abused by a physician but who have not made complaints or who have declined to have their name included in a mandatory report

(patients must consent to be named in a mandatory report) from accessing funding for therapy. This is more restrictive than current practises followed by the College's Patient Relations Committee.
    - Individuals who have not made complaints or who have not been named in mandatory reports should not be excluded from funding.

2. Regulation-Making Power: Investigative and Discipline Processes

- As described in Section B under 'Sexual Abuse', *a) College Processes, Functions and Duties,* the Bill grants the Minister the power to develop regulations to "clarify" how the ICRC and Discipline Committees are to perform their functions with respect to matters involving allegations of a member's misconduct of a sexual nature, and providing for further functions and duties of those committees (s. 43(1)(w) RHPA).

Analysis:

- These provisions represent a fundamental change and raise operational questions.
- With respect to the regulations regarding sexual abuse investigations, it is unusual and problematic to detail a complex process like an investigation through regulation.
    - We are supportive of consistency of investigative processes where possible yet we want to ensure that we retain the ability to employ best and current practises in our investigations.
    - It is unclear how a regulation could set out the process in a manner that would be sufficiently nuanced so as to be useful and applicable. We feel that the best approach to ensure consistency is to do so by policy as opposed to regulation.
    - If changes need to be made to processes, and the processes are set out in regulation, it is out of our control, time-consuming and uncertain. We are always improving our approach to investigations and worry that we will lose the ability to make necessary and swift improvements.
- Further, the provision only relates to sexual abuse investigations. In doing so, the provision assumes that sexual abuse matters are always clearly distinguishable from other misconduct issues at the investigation stage. That assumption does not accord with the College's experience. In reality, some matters may initially appear to be clinical in nature, yet as the investigation proceeds, be revealed to be of a sexual nature.
- With respect to the duties and functions of Committees, the provisions raise questions about what new functions and duties of the ICRC and Discipline Committees are being contemplated. Functions of statutory committees are currently set out in the statute and arguably belong in the statute.

3. Regulation-Making Power: College Committees and Governance

- As specified in section B, under the heading 'Increased Ministerial Powers' the Bill grants the Minister the authority to make regulations with respect to College Committees and Governance.

Analysis:

- This is a fundamental change that has the potential to significantly change existing College governance processes.
- Typically, significant governance-related changes are addressed in legislation where they are set by the legislature as opposed to regulation where they are set by the government/ministry. For example, currently, some of the more significant quorum requirements are set out in statute as opposed to regulation (e.g. quorum requirement that there be two public members of Council and one professional member of Council on Discipline Committee panels).
- Currently, matters relating to committee composition are set out in bylaw. There is a significant loss of flexibility to colleges by enshrining these matters in regulations rather than in bylaws.
- Again, we are regularly improving and changing our by-laws on these issues; to address things like qualifications and disqualifications, in response to new and unforeseen situations that arise. Putting these things in regulation makes us unable to be responsive to problems as they arise. One-size fits all approaches may compromise the ability of some colleges to fulfill their mandates.

4. Sexual Abuse: Definition of Patient

- As stated in Section B, the Bill proposes to include a definition of patient for the purpose of sexual abuse allegations
- The Bill also adds an additional regulation-making power so the Minister can develop regulations specifying further criteria defining patient for the purpose of sexual abuse (s. 43(1)(o) RHPA).

Analysis:

- The definition of 'Patient' as proposed in the Bill, and specifically the one-year time period included in the definition, poses a number of challenges. We understand and are supportive of the Government's overall objective but are concerned about the unintended outcome.
- The wording of the current provision makes it impossible to apply the definition. It defines the doctor-patient relationship for matters of sexual abuse in terms of individuals who have been 'patients within the last year' but does not specify when the one-year period begins (i.e. within the last year of what?).
- Additionally, the definition implies that once one year from an undefined event has elapsed, individuals will no longer be considered patients. This would permit physicians to engage in a sexual relationship with such individuals. This may not always be appropriate. For instance, in some physician-patient relationships where the contact has been enduring (as in psychotherapy), it may never be appropriate for a physician to form a sexual relationship with a former patient.
- Limiting the definition to sexual abuse matters poses significant challenges in instances where there are blended allegations (sexual and non-sexual), or where it is difficult to determine if the conduct was sexual, and it is not clear whether the conduct occurred before or after termination. This would increase the complexity of hearings and create risk of legal error by discipline panels.

5. Alternative Dispute Resolution

- As stated in Section B under the heading 'Other Changes', Bill 87 includes a number of amendments to the ADR process/scheme.

Analysis:

- The language of these provisions; specifically the requirement to rely on ADR when the College cannot access the details of resolutions that may pose risks.
- It allows for the possibility that the College may endorse a resolution reached between a physician and a patient through ADR that does not protect or serve the public interest. There is no acknowledgement/protection of the public interest in a private dispute resolution mechanism.

<u>HOUSEKEEPING/DRAFTING ISSUES</u>

1. New regulation-making power for the Minister to prescribe additional functions for the patient relations program.

Analysis:

- We support adding to the functions of the Patient Relations Program.
- The concerns with the proposed provision are technical in nature; statutory functions are important and should be set in legislation where they can be considered by the legislature.

2. Funding for therapy: expansion to cover additional expenses

Analysis:

- The College supports the provision that would enable funding to cover related expenses such as child care or medication. This provision is consistent with Council's recommendations for legislative change made previously as part of the College's Sexual Abuse Initiative.
- Concerns are raised however with respect to the drafting and language used.
- The language of the provision suggests that individuals must use their funding for therapy within five years of the abuse taking place.
    - Council has previously advocated for any timeline associated with funding to be removed. This is in recognition of the reality of how individuals recover from trauma. Individuals may not seek therapy immediately following abuse. When therapy is sought, individuals may not necessarily do so in a consistent or frequent manner, but rather may take breaks and return to therapy after some time.
    - Additionally, from a technical perspective, it isn't clear whether the government has the authority to prescribe circumstances in which a person's eligibility to receive funding ceases.

- The language of the provision also suggests that the amount of funding awarded should be reduced by the amount covered by OHIP or a private insurer. Certainly it is important to ensure that there is no duplicate payment for therapy. Council had previously asked government however, to amend the legislation in order to clarify that each invoice for therapy provided would be reduced by any applicable coverage

(OHIP or private insurer) but that the total overall sum of funding allotted to each successful applicant not be reduced. This was advanced to ensure that the College was able to provide applicants with the maximum amount of funding that is possible and that is approved by the Patient Relations Committee.

3. Transparency: Public Register

- As indicated in Section B, the Bill includes a number of provisions relating to the public register. Specifically, the Bill specifies elements that must be included in the register.
- The College supports the expansion of the information contained on the public register. The College has made a number of bylaw changes over the past several years to ensure information about Ontario physicians is available. Our objective is to ensure that patients have access to information to help inform their health care decisions.
- Some housekeeping/drafting issues are identified below.

Analysis:

- The Bill's proposed amendments with respect to the contents of the register are slightly different from what is currently set out in College bylaw.
- The College will still be able to add more things to the register than are required by regulation, which is important.
- The College will have some wording changes to suggest, for example, the proposed amendment requires the College to post on the register where there is a "failure to make a finding". This language should be changed to 'no finding was made'. The College asked the Government to amend the Health Professions Procedural Code to allow Colleges to publish Discipline Committee 'no findings' on the register but the wording in the Bill does not reflect this request and needs to be amended.
- Other wording changes include the way in which former members are referred to; and concern with respect to the way acknowledgements or undertakings are referred to (para 11).

4. Transparency: Public Register – Duty to correct information

- As stated in Section B, under the heading Transparency, the Bill includes an amendment that imposes a duty on the Registrar to correct any information in the public register where a member demonstrates that the information is incomplete or inaccurate.

Analysis:

- The College has an existing obligation to have fair and accurate information on its register and currently has processes in place to manage its register and to make corrections when necessary.
- If enacted this provision could impose a significant administrative burden on Colleges particularly in relation to information alleged to be 'incomplete'. Registers typically include summaries of information which by their nature are not 'complete'.

5. Sexual Abuse: Interim power to restrict/suspend

- As stated in Section B of this brief, the Bill includes a power for the ICRC to restrict or suspend prior to a referral to the Discipline Committee or to the Fitness to Practice Committee.

Analysis:

- The College had requested that government provide colleges with this power, however amendments are needed to the language in the Bill in order to make it workable for the College.
- Language is needed to give ICRC the ability to impose terms, conditions and limitations during a fitness to practice inquiry or during a during a Registrar's investigation.
- Amendments are required to clarify the duration of interim orders, the ability to amend orders and the ongoing existence of the power to ensure patient protection.

6. Sexual Abuse: Mandatory revocation – immediate suspension power

- As indicated in Section B, the Bill includes provisions that would result in immediate suspension of members in specific instances: where they have been found guilty of sexual abuse, mandatory revocation applies, and the penalty hearing has been deferred.

Analysis:

- The College is supportive of the provisions in substance. It is consistent with legislative change Council approved as part of its Sexual Abuse Initiative.
- The issue with the provision as worded is that it is more limited in scope than what Council sought. The Bill's provision is specifically connected to findings of sexual abuse that trigger mandatory revocation; it does not extend to other forms of misconduct that trigger mandatory revocation (for example, convicted of an offence at a different health regulatory college, convicted of prescribed offence).
- In order to adequately protect the public, the College believes that the immediate suspension power should be extended to cover all professional misconduct for which there is a penalty of mandatory revocation.

7. Withdrawal of complaint

- As indicated in Section B under the heading 'Other Changes' Bill 87 includes provisions that would permit the Registrar to withdraw a complaint at the request of the complainant prior to any action being taken by a panel of the ICRC.

Analysis:

- The College has previously asked the government for greater discretion in managing complaints to provide the necessary latitude to focus attention to those matters that are more substantive such as those about care and professionalism.
- The Bill's provision regarding withdrawal of complaints does not provide meaningful assistance. Justice Goudge in his recent review, *Streamlining the Physician Complaints Process in Ontario* recommended the College have the authority that exists in Alberta where the Registrar or Complaints Director be required to conduct

an early review of public Complaints and be given the power to dismiss a Public Complaint where satisfied that there is no reasonable prospect of an outcome from the ICRC other than "No Action." Justice Goudge recommended that in such cases complainants be provided with brief written reasons and the ability appeal decisions to ICRC.

D. ADDITIONAL LEGISLATIVE CHANGE PROPOSALS

- In addition to advancing the Proposed College Responses as set out in Section C, there are other priority amendment areas identified below that the College may wish to advance as part of its submissions on Bill 87.
- These are considered here for strategic reasons, as the RHPA is not opened very frequently. The proposals captured under the first and second headings 'Amendments to protect patients' and, 'Amendments to support public members of Council' and better protect the public interest and enhance regulatory processes' have been previously advanced by the College.

1. Amendments to protect patients

i) Give the College the discretion to provide information to police about non-members.

- Currently, the College can only provide information to police about members. Giving the College discretion to share relevant information would allow the College to provide information about non-members in appropriate circumstances where it is in the public interest to do so.
- This discretion would be particularly important in cases where the patient or victim is not cooperating with the College or police, and there is a strong public interest in the police being able to investigate. We note that our experience shows that this would be helpful within the context of opioid related investigations (and diversion activity).

ii) Increase the threshold for when third party records are ordered to be produced and guarantee standing to patient/complainant on motions to disclose confidential records.

- One of the most invasive aspects of a Discipline hearing for patients/complainants (in sexual abuse hearings) is the ability of the subject physician to access and then reveal publicly at a hearing details of their private medical records, which can include psychiatric records, records of therapy sessions, and other records with extremely confidential information.
- This amendment would incorporate a specific elevated threshold for the production and disclosure of confidential records in College Discipline proceedings and require that a patient/complainant whose records are the subject of such a motion automatically be granted full standing on the motion if requested.
- This would help ensure an appropriate balance between the privacy interests of victims and/or witnesses and the interest of the physician in having access to

information to assist in defending against serious allegations in a regulatory context.
  - Also, it would help ensure patients/complainants can participate in the process to determine whether their confidential records can be released.

2. ***Amendments to support public members of Council and better protect the public interest and enhance regulatory processes***

- It is proposed that the College seek an amendment to allow Non-Council Public members to be included in the Quorum for the ICRC and Discipline Committee.

- It is also proposed that an amendment be sought to remove barriers in the legislation that prevent Colleges from compensating public Council members for their work.
  - The RHPA requires that most of the College's statutory committees include at least one public member of Council to establish a quorum. The Discipline Committee requires two public members of Council to form quorum for each panel.
  - Some public members are contributing more than 150 days per year and the average contribution is now more than 80 days per year. This workload is overwhelming and not sustainable for the public members and as a result, we are facing increased challenges convening discipline and ICRC panels.
  - The College is seeking an amendment to the RHPA to allow for non-Council members (public representatives who do not hold a seat on our Council) to be appointed to sit on the College's ICRC and Discipline Committees to meet the need for public representation.
  - The College Council supported a position in 2015 and 2016 to seek legislative change to allow Colleges to provide compensation to public members of Council. The College has a longstanding concern with the inadequacy of public member compensation ($150.00/day).

3. New proposals for legislative change

i) Amendments to confidentiality provisions to enable the College to share non-nominal data for research/public health

  - Section 36 of the RHPA states that anyone working with/for a College must keep all information that comes to his or her information in the course of his/her duties confidential and then lists a series of exceptions to that duty.
  - It is proposed that an amendment be sought to expand the exceptions to the duty of confidentiality to make it clear that the College can communicate non-nominal information.
  - This amendment would facilitate the research work the College is doing and reduce the risk associated with a complaint about the way in which the College uses its data.

ii) Amend the RHPA to exclude College proceedings from the requirement in the Mental Health Act which require either patient consent or a court order to enter evidence relating to care of a patient in a psychiatric facility.

- A recent decision of the Discipline Committee has determined that before evidence can be led in a hearing regarding any care provided in a psychiatric facility (which includes most hospitals where mental health care is provided), the College needs the consent of the patient to whom the information relates or a court order, which must be obtained on notice to the patient.
- This means that the College would have to locate and notify each patient whose information may be the subject of evidence at a hearing – including expert evidence – before the hearing. In many cases that are not triggered by a complaint (i.e. most s. 75 investigations) patients would not be aware that their chart has been obtained and will be the subject of expert evidence. The information on the chart may no longer be accurate and the challenge of locating and notifying patients is significant.
- Further, patients with some psychiatric conditions could find it extremely alarming to learn that the College is reviewing their medical records and viewing the details of their care. It seems the purpose of this section of the *Mental Health Act* is to protect the confidentiality interests of patients which the College already does in its proceedings. Further, the public interest in being able to review a physician's psychiatric care is significant and this requirement impedes its ability to do so.

E. NEXT STEPS

- Given the significance of Bill 87 and its direct implications for patients and the College, it is anticipated that the College will participate fully in the legislative process.
- This will include making submissions to government and the Legislative Standing Committee.
- Council's feedback on Bill 87 will directly inform the College's submission to government and any ongoing advocacy activities with respect to the Bill.

DECISIONS FOR COUNCIL:

- Council is asked for its feedback on the Bill and its direction on the following:

1. Does Council agree with the Analysis set out in Section C?
2. Does Council support advancing the additional proposed legislative changes set out in Section D?

3. Are there any other issues that Council may have with the Bill that have not been captured?

CONTACT: Louise Verity
Andrea Foti
Vicki White/Lisa Brownstone
Rocco Gerace

DATE: February 16, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: Opioid Update and Guidelines Consultation

CPSO

1. **Investigations**
2. **Other Activities**

Provincial

3. **Minister's Strategy to Prevent Opioid Addiction and Overdose**

National

4. **Minister's Opioid Conference and Summit**
5. **Opioid Recommendations/Guidelines Consultation**

DATE: February 24, 2017

For Information/Discussion

ISSUE:

This briefing note summarizes recent developments and the current status of on-going opioid work at the CPSO.

CPSO ACTIVITIES

1 Investigations

The CPSO is currently investigating multiple physicians identified by NMS data who met the following criteria:

- 8 or more patients receiving 650 OME/day; AND
- a single dispense of 20,000 OME (one opioid only).

The investigations are proceeding quickly and are anticipated to be considered by ICRC by June.

Further analysis of the characteristics of the physicians and their practices will be done once the investigations are complete as part of an evaluation on this group of investigations.

Given the potential for investigations to result in patient terminations, efforts are being made to prevent sudden cessation of medications given the risk to patients.

2 Other Activities

Model: An internal structure has been established to manage this project, with a steering group and 3 working groups focusing on investigations, education and data.

ICES: In addition to an analysis of the characteristics of the physicians identified by this algorithm, the CPSO is also working with ICES to identify physician factors that are associated with higher prescribing, based on a review of *all* Ontario prescribers and their prescribing patterns. This work has just begun, but ultimately will help to focus our educational or investigative efforts more specifically.

HQO: Health Quality Ontario is developing quality standards relating to Opioid Use Disorder and Opioid Prescribing for Pain. It is also working towards including opioid prescribing information in the Primary Care Practice Reports that are currently available to physicians. The CPSO is working with HQO to inform the Practice Reports and possibly make them easier to access for family practice physicians.

PROVINCIAL

3 Minister's Strategy to Prevent Opioid Addiction and Overdose

The Minister of Health released an opioid strategy in October, 2016 which includes multiple actions, organized around 3 themes: Opioid Prescribing/Monitoring, Pain Treatment and Harm reduction. Information about this strategy was provided at the last meeting.

The Minister's overall strategy draws heavily on recommendations made by the Methadone Advisory Task Force, which was convened to address specific concerns relating to the prescribing of methadone.

The Minister's strategy does not include an overall vision for ongoing prescription monitoring, which is something the College will be raising in future discussions.

NATIONAL

4 Opioid Conference and Summit

The Federal Minister of Health and Ontario Minister of Health co-hosted an Opioid Conference and Summit in November 2016 in Ottawa.

Participants were asked to commit to an action plan, which is available here **http://www.healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/opioids-opioides/conference-cadre/statement-declaration-eng.php**

The CPSO commitment is:

- **By June 2017**: Collaborating with the Ontario Ministry of Health and Long-Term Care on the recently released strategy and development of a plan to use Narcotics Monitoring System data held by the Ministry to promote patient safety. This includes:
    - identifying possible high risk prescribing and referring to regulatory bodies for follow up; and
    - developing a plan to identify low risk prescribing and providing a variety of educational interventions, including tools, that are tailored to individual needs of prescribers.
- **By December 2017**: Publicly reporting, as permitted by legislation, on the outcomes of the current approach.
- **By December 2017:** Updating existing policy to reflect revised Canadian Guidelines and Health Quality Ontario Quality Standards (if available).
- Once all physicians have access to narcotics profiles, inclusion of expectation in policy for physicians to check the medication profile prior to prescribing narcotics.
- Using prescribing information (comparative prescribing reports or prescribing data), when available, to inform educational approaches in conjunction with assessment of physician practice.
- Supporting and contributing to a broader strategy to ensure necessary supports are available to patients and other health professionals.

Participants in the action plan have been asked to report on their progress monthly until March 2018. Progress on the action plan will be publically reported quarterly.

5 Opioid Recommendations/Guidelines Consultation

The draft recommendations for Use of Opioids in Chronic Non-Cancer Pain were released for consultation on January 30, 2017 by the Michael G. DeGroote National Pain Centre at McMaster University. Feedback on the guidelines is due by February 28, 2017.

Information about the development of the guidelines and a link to provide feedback is available here http://nationalpaincentre.mcmaster.ca/guidelines.html.

There are 10 draft recommendations, 4 of which are strong recommendations. A summary of the draft recommendations is set out below. As anticipated, the draft recommendations suggest starting patients on a dose lower than 50 OME and not exceeding 90 OME. This is consistent with recommendations made by the US CDC Guideline for Prescribing Opioids for Chronic Pain released last year.

The full Canadian guideline, which will include the recommendations as well as best practice and other information, will be released in March, after feedback on the draft recommendations is received.

Generally speaking, the CPSO does not comment on specific clinical guidelines. However, given the importance of the opioid issue, and our involvement in the development of the previous version of the guidelines, a CPSO response will be provided with the direction of the Executive Committee.

The CPSO response will focus on the clarity of the guidelines, and their usability for clinical and regulatory purposes. Further information will be provided at the Council meeting.

	Draft Recommendation	Strength	Evidence Quality
1	When considering first-line therapy for patients with chronic non-cancer pain, we recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids	**Strong**	Low
2	For patients with chronic non-cancer pain, without current or past substance use disorder and without other current serious psychiatric disorders who still experience persistent problematic pain despite optimized non-opioid therapy, we suggest a trial of opioids rather than continued non-opioid therapy.	Weak	Moderate
3	For patients with chronic non-cancer pain with an active substance use disorder we recommend against the use of opioids	**Strong**	Low
4	For patients with chronic non-cancer pain with a current serious psychiatric disorder whose non-opioid therapy has been optimized, and who still experience persistent problematic pain, we suggest stabilization of the psychiatric disorder before considering a trial of opioids	Weak	Low
5	For patients with chronic non-cancer pain with a history of substance use disorder, whose non-opioid therapy has been optimized, and who still experience persistent problematic pain, we suggest continuing non-opioid therapy rather than a trial of opioids	Weak	Low
6	For patients with chronic non-cancer pain beginning long term opioid therapy, we suggest restricting the prescribed dose to under 50mg morphine equivalents daily	Weak	Moderate
7	We recommend restricting the prescribed dose to under 90mg morphine equivalents daily rather than no upper, or a higher limit on dosing	**Strong**	Moderate
8	For patients with chronic non-cancer pain currently using 90mg morphine equivalents of opioids per day or more, with persistent problematic pain and/or problematic side-effects, we suggest rotation to other opioids rather than keeping the opioid the same	Weak	Low
9	For patients with chronic non-cancer pain currently using 90mg morphine equivalents of opioids per day or more, we suggest tapering opioids to the lowest possible dose, including discontinuation, rather than no change in opioid therapy	Weak	Low
10	For patients with chronic non-cancer pain using opioids and experiencing serious challenges in tapering, we recommend a formal multidisciplinary program	**Strong**	Moderate

NEXT STEPS:

The CPSO is focusing on investigation of the current matters. Internal working groups are also working on recommendations for next steps, in the following areas:

- The next iteration of the algorithm/threshold
- Possible alternatives to Registrar's Investigations (RI's) for managing these matters
- Educational partnerships and resources relating to opioid prescribing
- Data/evaluation/reporting.

The Executive Committee has asked for an overall opioid strategy to be developed, and this will be considered in March and brought to May Council for discussion.

Staff will continue to monitor the various initiatives and work with government, partners and stakeholders to move forward.

DECISION FOR COUNCIL:

For Information/Discussion

Contact: Maureen Boon, Extension 276

Date: February 6, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **Strategic Reporting - 2017**

DATE: **February 2017**

For Information

ISSUE:

The College's work is guided by its Strategic Plan which was approved by Council in September 2014. The Strategic Framework is attached for reference at Appendix A. The Strategic Plan charts the course to our vision: Quality Professionals - Healthy System - Public Trust.

College activities are focused on this framework targeted toward 4 high level priorities:

1. Registration
2. Physician Competence
3. Investigations, Discipline and Monitoring, and
4. Operations.

Progress towards the goals set out in the Strategic Plan is reflected in the attached Strategic and Operational Dashboard, attached at Appendix B. The Dashboard provides an overview of performance against targets set for each area. These are the final results for 2016.

The CPSO is nearing the end of its current strategic plan, which extends until 2018. 2017/18 will represent interim reporting years as the organization transitions to new leadership and begins preparations for a new strategic plan.

For 2017, a Corporate Plan has been developed to guide the operations of the College. The Corporate Plan framework is attached at Appendix C.

Ultimately, the goal will be to have both a strategic and operational plan, with associated reporting.

The 2016 Dashboard as well as the reporting plan for 2017/18 will be presented as part of the Registrar's Report at Council.

DECISION FOR COUNCIL: For information only

Contact: Rocco Gerace
Maureen Boon, ext 276

Date: February 3, 2017

Appendices:
A: Strategic Framework
B: 2016 Dashboard
C: Corporate Plan Framework

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

VISION

QUALITY PROFESSIONALS, HEALTHY SYSTEM, PUBLIC TRUST

PRIORITIES

- REGISTRATION
- PHYSICIAN COMPETENCE
- INVESTIGATIONS, DISCIPLINE & MONITORING
- OPERATIONS

STRATEGIC INITIATIVES

- QUALITY MANAGEMENT PARTNERSHIP
- EDUCATION
- TRANSPARENCY
- INFORMATION MANAGEMENT

PRINCIPLES

- INTEGRITY
- ACCOUNTABILITY
- LEADERSHIP
- COLLABORATION

Strategic Dashboard – FINAL 2016

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Q3 Status	FINAL	Comments
Optimize Registration	Target to be developed for 2017						
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year					As of December 31, 2016 –2606 assessments completed, achieving 100% completion of target.
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology					Data not yet available Initial reports will be provided to physicians later in 2017

Operational Dashboard – Q3 2016

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Q3 Status	FINAL	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks					Credentials Applications 4470 of 4509 applications (99%) Registration Committee Applications 1115 of 1226 applications (91%)
Assure/Enhance Physician Competence	Increase input in policy	130 responses/policy			Q3 YTD		2016 consultations: 10 2016 consultation responses: 1058. Average # of responses/consultation: 106.
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years					82% are either current (have been reviewed in the last 5 years) or under review.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.					January 1st – Dec 31st, 2016: 90% of high risk investigations were completed in an average of 185 days, (40 investigations involving 35 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year					January 1 – Dec 31, 2016: 90% of hearings (45) began on average, 340.9 days (11.2 months) from the NOH date.

[1] Does not include registration policies

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Q3 Status	FINAL	Comments
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>					January 1 - Dec 31, 2016: 90% of uncontested decisions (31) were released , 41.9 days (1.4 months) from the last hearing date.
		<u>6 months for contested (C)</u>					January 1 – Dec 31, 2016: 90% of contested decisions (22) were released, 150.6 days (5.0 months) from the last hearing date.
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)					A&C: 86% (28,261 of 32,772) calls managed live PPAS: 92% (49,330 of 53,803) calls managed live Combined: 90% (77,591 of 86575) live response rate
	Improve service level targets	10% call abandonment					A&C 4,492 calls abandoned: 13% PPAS 2,768 calls abandoned: 5% Combined call abandonment rate: 8%
	Media coverage	80-100% positive or neutral					2016 results: Positive stories: 17% (236) Neutral stories: 70% (961) Negative stories: 13% (169) Total # stories in 2016: 1,366

LEGEND

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
Optimize Registration	Reduce processing time for Registration Applications	Time from application received by College to (a) first application contact for non-registration committee cases; (b) first applicant contact for registration committee cases	90% of applications meet processing time of (a) 3 weeks (b) 4 weeks	= > 90%	70-89%	<70%
Assure and Enhance Physician Competence	Every physician assessed every 10 years	# of physician assessments in College programs	2600 assessments/year	Tracking to >= 2600	Tracking to 2300-2599	Tracking to <2300
	Quality Management Program – implementation	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology	80% of physicians receiving reports	80%+ receiving reports	50-79%	<50%
	Increase participation in development of policy	Average # of responses/policy	130 responses/policy	>130 responses	100-129 responses	<100 responses
	Existing policies are current & relevant	Policies reviewed and updated regularly	80% of policies reviewed within 5 years	80%+ reviewed within 5 years	60-79%	<60%
Optimize Investigations, Discipline and Monitoring Processes	Reduce time for completion of high risk investigations	# days to complete investigation	90% of High Risk investigations completed in ***243 days or less*.**	90% High Risk investigations done in <=***243 days*.**	90% High Risk investigations done in ***244-256 days***.	90% High Risk investigations done in ***257 days+***.
	Schedule discipline hearings more quickly	Time from referral (notice of hearing) to hearing date	Hearings begin within 1 year	90% began within 365 days (1 yr)	90% began w/i 366-457 days (12-15 mos)	90% began more than 457 days (15 mos)
	Reduce discipline decision release times	Time from hearing date to decision release date	Uncontested (UC): 2 months Contested (C): 6 months	90% released <= 2 mos (UC) <= 6 mos (C)	90% released 2-4 mos (UC) 6-8 mos (C)	90% released > 4 mos (UC) > 6 mos (C)
Operational Excellence	Improve service level targets	Live answer for PPAS and A&C	85% live answer	85% or greater	75-85%	Less than 75%
	Improve service level targets	Call abandonment rate	10% call abandonment	10% or less	11-15%	Greater than 15%
	Media coverage	Positive or neutral media coverage	80% positive/neutral media coverage	80-100%	60-80%	<60%

2017 Corporate Plan Framework

Strategic

- QMP
- Education
- Transparency+
- Data/Info Management

Regulatory

- Facilities/Premises
- Investigations/Hearings/Monitoring
- Registration
- Assessments
- RHPA Review*

Risk

- Infection Control
- Opioids+
- Physician Factors
- Regulatory Modernization (Governance)

Operations

- Operational Planning
- Financial Integrity
- Process/Program Improvement
- Transition Strategy*

*Focus in 2017-2018 only

+Category likely to change in next Strategic Plan

Strategic

- Includes strategic initiatives
- Determined by Council via the Strategic Plan
- Initiatives do not change over course of Strategic Plan
- Reported to Council via strategic dashboard

Regulatory

- Includes core regulatory functions
- Represents significant proposed changes to scope/nature of existing core function OR additional regulatory function
- Categories do not change
- Reported to Council via Registrar's report

Risk

- Includes major potential risk areas
- Categories will change depending on environment
- Items in this category could transition to strategic initiatives
- Reported to Council via Registrar's report

Operations

- Includes key operational functions (budget, IT, HR, space)
- Categories do not change (with exception of transition activities in 2017/18)
- Reported to Council via operational dashboard

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMBER TOPICS

No Meeting Materials

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **RENEWAL OF THIRD PATHWAY STATUS – MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA (MDPAC) (FORMERLY GENERAL PRACTICE PSYCHOTHERAPY ASSOCIATION (GPPA)**

DATE: February 2017 Council Meeting
For Information

ISSUE:

Council is being updated on the Education Committee's decision to extend the Medical Psychotherapy Association of Canada's status as a "third pathway" CPD tracking organization until September 2019.

BACKGROUND:

- A 2011 change to Ontario Regulation 114/94 under the *Medicine Act, 1991* requires CPSO members to participate in CPD that meets the requirements set by the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), or a "third pathway" approved by Council.

    - The Medical Psychotherapy Association Canada (MDPAC), formerly the General Practice Psychotherapy Association (GPPA)[1], is currently the only third pathway and was approved as a CPD tracking organization by the CPSO Education Committee in September 2012 and Council in February 2013 (see Appendix A for Approval Criteria).
        - Approval was for three years (to 2016) with a requirement for annual reports by MDPAC to the Education Committee.
        - At the time of the 2012/2013 decision, there was no clear indication of how the status of the MDPAC would be re-

[1] The CPSO received a letter from MDPAC/GPPA dated May 20th, 2016 notifying us about the name change which had been approved by the GPPA's membership on December 20th, 2015.

evaluated after three years.

- Given the lack of review criteria for MDPAC's third pathway status, at its February 2016 meeting the Education Committee identified content requirements for MDPAC's third annual report, and asked them to address the following items based on the original application criteria, and questions that had come up based on previous annual reports and presentations by MDPAC:

    1. Any key changes from the original application.
    2. Further documentation about their approach to evaluating their CPD program to respond to changing needs and requirements.
    3. An update on the implementation of their audit policy.
    4. Further documentation of any processes to follow up with members who are not compliant with the organization's requirements.
    5. Their plans for ensuring the future sustainability of their CPD system.
    6. If and how they planned to incorporate CanMEDS 2015, including consideration of roles outside the Medical Expert role.
    7. Any anticipated trends in CPD (including upcoming changes to CFPC's MainPRO program), and how MDPAC planned to address them.

CURRENT STATUS:

- In September 2016, based on MDPAC's annual reports and presentations to the Education Committee, the Education Committee decided to extend MDPAC's status for a further three years, until September 15th, 2019, with a continued requirement for annual written reports and a presentation to Committee in 2019.
    - *Appendix B* is a copy of MDPAC's 2016 three year report and *Appendix C* is a copy of MDPAC's presentation to the Education Committee on September 14th, 2016.

- The Committee's decision was communicated to MDPAC by email in October 2016 that indicated a formal letter was pending.

- However, upon reviewing Council's original decision in 2013 it was unclear whether Council should approve the Education Committee's decision to extend the third pathway status, or whether this item should go to Council as an information item from the Education Committee.
    - A second email was sent to MDPAC indicating that the Education Committee's decision would be shared with the Executive Committee who would be asked to decide on next steps.

- At its January 2017 meeting, the Executive Committee decided that this item could go to Council as an information item.
    - Appendix D is the final letter communicated to MDPAC by the Chair of the Education Committee.

- During its January meeting, the Executive Committee also requested that the Education Committee develop a process for future renewals, to be approved by Council and communicated to MDPAC before they are up for renewal in September 2019.
    - This new process should include review and approval by Council.

Contact: Wade Hillier, Ext. 636
Jennifer Fillingham, Ext. 523

Date: February 1st, 2017

Appendices:

Appendix A: Approval Criteria for Third Pathway Organizations – Approved by Council, February 2012

Appendix B: MDPAC/GPPA Written Report to CPSO, September 2016

Appendix C: MDPAC/GPPA Presentation to Education Committee, September 14, 2016

Appendix D: Letter to MDPAC from Education Committee, January 2017

APPENDIX A

Criteria and Indicators for Organizations Wishing to be Approved by Council as a Program of Continuing Professional Development (CPD) for members

In February 2012, Council approved the following criteria and indicators for organizations wishing to be approved by Council as a program of continuing professional development (CPD) for members:

1. There must be clear statement of purpose for the CPD system
    a. Describe the values, goals and objectives of the CPD system

2. Physicians are represented and included in decision making within the governance of the organization
    a. Provide flow chart and/or description of your governance, relevant by-laws

3. The organization has specific bylaws related to its governance and the CPD roles specifically, for example monitoring and adherence to standards, appeal mechanisms, consequences for non-compliance, conflict of interest, privacy and bias
    a. Specific bylaws are available for review

4. There must be a formal evaluation of the CPD program to respond to changing needs and requirements
    a. Describe the methods of evaluation and frequency

5. There must be a system to define the credits assigned to specific activities, credit weightings must be informed by educational evidence and there must be a documentation system for activities and outcomes
    a. Describe the type of learning activities, the credits for each (if

applicable), and the basis upon which your organization has made assignment decisions; describe the ways in which your organization tracks the outcomes from participation in education

6. There must be a formal analysis by the organization providing a rationale about how the organization's CPD program is deemed comparable to either the CFPC or RCPSC program
    a. Provide information to demonstrate how your organization has reviewed its comparability to the RCPSC or CFPC

7. There must be an audit system in place
    a. Describe how the audit establishes accountability of members; describe the mechanism by which the organization tracks the number and types of credits of the organization's members

8. There must be a rigorous system in place to follow-up with members who are not compliant with the organization's requirements
    a. Describe the nature and frequency of the monitoring system; describe the consequences of failing to adhere or comply with the organization's requirements

9. The organization must be able to transfer and share individual data with the CPSO
    a. Will the organization enter into a data sharing agreement with the College; how will data be available in a timely and useful format

10. There must be the ability to validate and ensure physician identity
    a. Does your organization use CPSO number, MINC, something else

11. The organization must have sustainability for its CPD system

a. Number of members, organization's budget, staff and Committee roles, responsibilities and expertise to promote evaluation and innovation; what accreditation system is used (if any); how the organization supports and advises individual members about their CPD

Medical Psychotherapy Association Canada
(formerly) General Practice Psychotherapy Association
312 Oakwood Court
Newmarket, ON L3Y 3C8
Tel: 416-410-6644
Fax: 905-895-1630
info@gppaonline.ca
http://www.gppaonline.ca

September 6, 2016

CPSO Education Committee,
c/o Jennifer Fillingham, M.Ed., PMP
Education Liaison
Research & Evaluation Department
College of Physicians and Surgeons of Ontario 80
College Street, Toronto, ON M5G 2E2

Dear Ms. Fillingham:
As you know, the General Practice Psychotherapy Association (GPPA) was approved as a CPD tracking organization by the CPSO Education Committee in September 2012 and CPSO Council in February 2013. This status is up for review in 2016.

The CPSO Education Committee met earlier this year and have requested that our 2016 report elaborate on some past discussion items and re-address several of the original approval criteria (outlined in Appendix A attached to your March 14, 2016 email to me. I am including a copy in this report for your reference.). This report and an accompanying presentation to the Committee will serve as the basis of the review of the MDPAC/GPPA's status.

Requested report items are:

1. Any key changes from the original application form (Criteria are outlined in your Appendix A)
2. Further documentation about the GPPA's approach to evaluating our CPD program to respond to changing needs and requirements. (Criterion #4, Appendix A)
3. An update on the implementation of the GPPA's audit policy, including statistics from 2015/2016 if available. (Criterion #11).
4. Further documentation of any processes to follow up with members who are not compliant with the organization's requirements (Criterion #8).
5. The GPPA's plans for ensuring the future sustainability of the CPD system (Criterion #11).
6. If and how the GPPA plans to incorporate CanMEDS 2015 into its CPD program, including consideration of roles outside the Medical Expert role.
7. Any anticipated trends in CPD (including upcoming changes to CFPC's Maintenance of Competence (MOC) program), and how the GPPA will address it.

Please see the following report for elaboration on the above. Thank you for your consideration.

Sincerely,

Muriel J. van Lierop, MBBS, MGPP
Chair, CPSO/CPD and Professional Development Committees

Appendix A – Criteria and Indicators for Organizations Wishing to be Approved by Council as a Program of Continuing Professional Development (CPD) for members

In February 2012, Council approved the following criteria and indicators for organizations wishing to be approved by Council as a program of continuing professional development (CPD) for members:

1. There must be clear statement of purpose for the CPD system

a. Describe the values, goals and objectives of the CPD system

2. Physicians are represented and included in decision making within the governance of the organization

a. Provide flow chart and/or description of your governance, relevant by-laws

3. The organization has specific bylaws related to its governance and the CPD roles specifically, for example monitoring and adherence to standards, appeal mechanisms, consequences for non-compliance, conflict of interest, privacy and bias

a. Specific bylaws are available for review

4. There must be a formal evaluation of the CPD program to respond to changing needs and requirements

a. Describe the methods of evaluation and frequency

5. There must be a system to define the credits assigned to specific activities, credit weightings must be informed by educational evidence and there must be a documentation system for activities and outcomes

a. Describe the type of learning activities, the credits for each (if applicable), and the basis upon which your organization has made assignment decisions; describe the ways in which your organization tracks the outcomes from participation in education

6. There must be a formal analysis by the organization providing a rationale about how the organization's CPD program is deemed comparable to either the CFPC or RCPSC program

a. Provide information to demonstrate how your organization has reviewed its comparability to the RCPSC or CFPC

7. There must be an audit system in place

a. Describe how the audit establishes accountability of members; describe the mechanism by which the organization tracks the number and types of credits of the organization's members

8. There must be a rigorous system in place to follow-up with members who are not compliant with the organization's requirements

a. Describe the nature and frequency of the monitoring system; describe the consequences of failing to adhere or comply with the organization's requirements

9. The organization must be able to transfer and share individual data with the CPSO

a. Will the organization enter into a data sharing agreement with the College; how will data be available in a timely and useful format

10. There must be the ability to validate and ensure physician identity

a. Does your organization use CPSO number, MINC, something else

11. The organization must have sustainability for its CPD system

a. Number of members, organization's budget, staff and Committee roles, responsibilities and expertise to promote evaluation and innovation; what accreditation system is used (if any); how the organization supports and advises individual members about their CPD

MDPAC Report to the CPSO Education Committee 2016

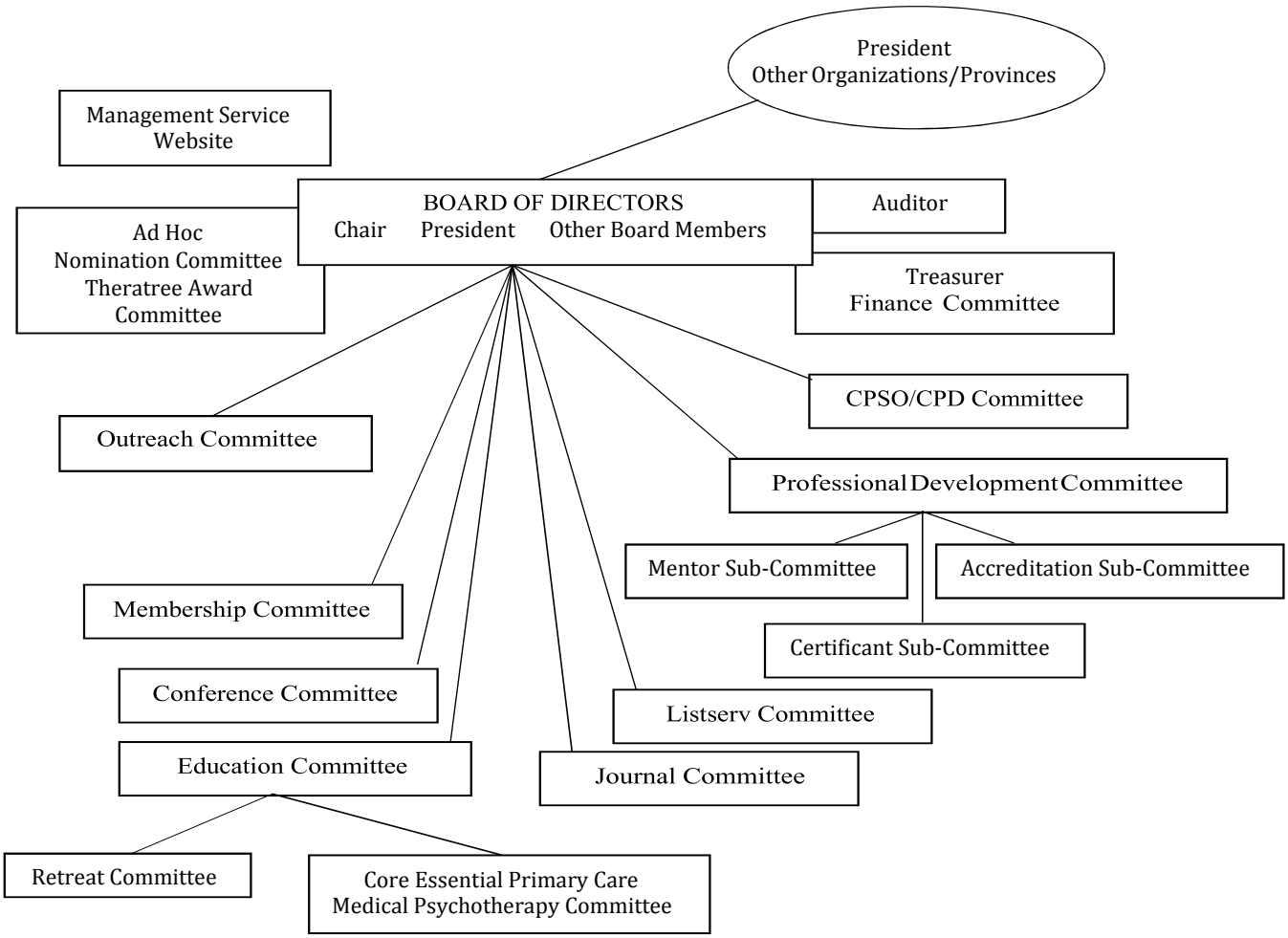
September142016

1. Any key changes from the original application form.

I. The name of the General Practice Psychotherapy Association has changed to Medical Psychotherapy Association Canada and our President and Chair of the Board have written and informed the CPSO of this. We are in transition to a new logo and new website. We are calling our organization MDPAC/GPPA during our transition.

II. Our organizational structure has changed slightly and the organizational chart is below:

Table I



III. Bylaws Updated The Federal Government changed the regulations for Not-for Profit Corporations. We have updated our By-Laws in accordance with these in 2014. See Appendix A. The main change is that we needed to have our financial year-end within 6 months of our AGM. We changed our financial year-end to December 31 as our AGM is at our Annual Educational Conference which is usually in April or May. We kept our membership year the same, October 1, one year to September 30 the next.

IV. Changes to approved credits

1. MDPAC/GPPA Listserv

In 2012 the Listserv could be claimed as Group CE or Continuing Collegial Interaction (CCI). Now it can be claimed as CCI only.

2. New Category - On Line Group CE

This new category of "on line learning for courses approved by the MDPAC" can be claimed for a maximum of 15 hours per cycle by Clinical CPSO/CPD, Certificant and Mentor members and 7.5 hours by Clinical members. If more entered than the maximum 15 (or 7.5) hours allowed, the computer programme will record the credits as Self Directed CE. (See Table III below).

Criteria for this On Line Group CE is to have all of the following in the module(s):
(a) didactic or required reading component;
(b) videotaped actual or simulated session as a teaching tool for each module;
(c) interactive component ("virtual therapist", posting of on-line comments or other interactive activity) and
(d) a self-assessment activity (quiz or test).

Table II

CE/Self-directed	CE/Group	Continuing Collegial Interaction (CCI)
Audio/Video tape Book/Journal CD-ROM Internet Teaching preparation Writing an article Peer assessment - preparation as assessee Peer assessment - review as assessor	Conference Course Seminar Workshop Teaching Online Group CE	Case supervision (as supervisor) Case supervision (as supervisee) Meeting (Committee, Board, AGM - GPPA or other) Discussion with colleague - e.g. case Peer Assessment Discussion (as assessor) Peer Assessment Discussion (as assessee) GPPA Listserv

Table III

The Maintenance of Competence Program of the MDPAC requires that members satisfy the following requirements:

Membership Categories	Continuing Education (CE) Activities Hours required over 3 years.			Continuing Collegial Interaction (CCI) Activities Hours required over 3 years.		Hours required per year minimum
	Total	Group learning activities	Self- learning activities	Total	Participation in GPPA Listserv	
Clinical members	36	20 minimum * (up to 7.5 hours can be MDPAC – approved online course)	16 maximum	36	16 maximum	12
Clinical CPSO/CPD Members (Using the GPPA for Accreditation by the CPSO)	75	40 minimum * (up to 15 hours can be MDPAC – approved online course)	35 Maximum	75	35 Maximum	25
Certificants & Mentors	75	40 minimum * (up to 15 hours can be MDPAC – approved online course)	35 maximum	75	35 maximum	25

It is necessary that half the required number of hours for each year (any combination of CE and CCI) be reported annually, on a regular basis. Clinical members need to report at least 12 hours per year and Clinical CPSO/CPD, Certificant and Mentor members need to report at least 25 hours per year.

V. We have developed a new web application for reporting credits. This was reported to the CPSO in 2015. The key changes are as follows:

- On opening the program there is a summary which gives the requirements for the year and/or the cycle and as well as the summary of the credits that have been approved to date. This allows members to know whether sufficient credits have been attained and to track their progress.
- On choosing an educational activity a definition of that activity is shown immediately so it is easy to see if the choice is correct.
- Membership committee members can review the credits entered and approve or reject these. If denied the reason is entered into the program for the member to see.
- The reviewing member is able to enter a question into the program and the member is sent to an email alerting them of the question, which the member can answer in the program.
- A question and answer section has been added which can be accessed by clicking onto the icon Q & A. This provides information about how to use the program and about educational credits which are allowed and those which do not qualify.

VI. Reference Manual for Approval of credits by Membership Committee members - when a member joins the Membership Committee they are trained by another member of the committee as to the process for approving. See Policy 3.1.A.vi.b. CE/CCI Monitoring (Appendix B) and also 3.1.A.vi.b.2 Procedure for Approving CE/CCI Records (Appendix C).

The Membership Committee has now developed a reference manual for approvers which explains the monitoring and approval process.

VII. Accreditation Sub-Committee

There was an Accreditation Sub-Committee of the MDPAC/GPPA in 2012 but very few applications for accreditation were made at that time. Many more applications are being made now.

Two types of application forms are now up on our website for education providers/applicants to access: one for conferences, seminars, courses etc. and one for online courses. A new category of credits has been developed which is specifically for Online Group CE. Only approved courses can be claimed for credits. So far only one course has reached the standard.

See Accreditation Application Forms (Appendix D and E), and the 2 internal forms (Appendix F and G) Note: The internal forms are used for communication between accreditors and are not shared with applicants. On reviewing these, a letter is sent to the organization that applied, which confirms or rejects the application and assigns the number of CPD credits for the educational activity.

A paid administrative assistant helps with this process by completing the Internal Form for the Accreditation Committee members to review. A Drop Box has been set up, which the administrative assistant manages. All applications are recorded on a Tracking Sheet and it is easy to see how far an application is in the accreditation process.

Very recently a charge has been levied for the accreditation process, to be paid at the time the application is submitted. These fees are on the lower end of those charged by most physician organizations and are necessary to offset the administrative costs of the accreditation process. See attachment.

VIII. Further Developments in Education

i. Retreat Committee and the ii. Core Essentials Primary Care Medical Psychotherapy Committee

i. Retreat Committee

The Retreat Committee was formed in 2011 in response to the goals developed in the Visioning meeting in February of that year. The purpose of the Retreat Committee, which reports to the Education Committee, is to organize a yearly weekend educational retreat for interested members of our organization as well as for other physicians with an interest in psychotherapy. The committee currently has seven members and meets approximately 6 times per year. The responsibilities of the committee include choosing topics and facilitators, organizing the venue and applying for accreditation.

The first retreat was held in November 2012 and have continued annually in either October or November since then. The attendance has always been full, with the event in 2015 selling out within a month of registration opening. There has been very positive feedback from the participants and the committee continues to conduct needs assessments to ensure that it is providing what the participants need and want.

Past retreats:

- "The Power of Self-care in Health Care: Caring for Ourselves as a Foundation for the Care of Others" Date: November 9-11, 2012
- "The Power of Self Reflection in Health Care: The Making of a Therapist from Family to Finish" Date: October 25-27, 2013
- "The Power of Self-Awareness in Health Care: When you take care of a client, who is taking care of you?" Date: November 7-9, 2014
- "Greater than the sum of our parts: Embracing Our Wholeness. Building Courage and Confidence in Challenging Times." Date: October 23-25, 2015

Upcoming retreat:

"Strengthening Self Care with Mindful Self Compassion" Date: November 4-6, 2016

ii. Core Essentials Primary Care Medical Psychotherapy Committee

The Outreach Committee of the MDPAC/GPPA was interested in developing a more integrated, comprehensive, educational series of psychotherapy courses for those doing psychotherapy as part of a medical practice. The planning is still in process and the committee is meeting every month to put this program together. The complete course will be at least two, maybe three week-ends for 30 hours or even up to 40 hours in total. See Terms of Reference (Appendix H).

IX. Policies Recognizing and Supporting our Volunteers

Volunteer Recognition Policy states that each of these committee volunteers receive a letter of recognition from the committee chair, and the President of MDPAC/GPPA, and $50 GPPA Appreciation Coupon (to be used for MDPAC/GPPA membership dues or conference registration fees).

In June 2013, a policy was developed to support our volunteers to pay for expenses when they travel on MDPAC/GPPA business. This ensures that, when the travel to the meeting has been approved by the Board, the registration fee (if there is one), travel expenses and the accommodation will be refunded to the member.

Policy 2.9 Volunteer Recognition Policy (Appendix I)
Policy 3.3.F Expenses Policy (Appendix J)

X. Changes to Membership Categories

i. Clinical CPSO/CPD Membership This new category was created for those choosing to use the MDPAC/GPPA as their pathway, who were not Certificant or Mentors Members. (The requirements for Certificant and Mentor Members is equivalent to that for Clinical CPSO/CPD Members)

Criteria: Any physician, who has passed LMCC licensure exam, is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics in Ontario. New Clinical CPSO CPD Membership (in Ontario) requires practicing a minimum of 51% Psychotherapy, Mental Health and/or Addictions. See Members Categories and Dues (Appendix K).

ii. Associate Membership The Associate Membership category was originally for non-physicians interested in psychotherapy. However, it has been decided to limit Associate membership to physicians only. See Members Categories and Dues (Appendix K).

iii. Mentor Emeritus The Mentor Emeritus category originally did not require educational credits be obtained although it was encouraged. Now Mentor Emeritus members are required to do continuing educational activities. See Members Categories and Dues (Appendix K).

XI. Documents with minor changes

Documents with minor changes such as for the renewal of membership process need to be up-dated each year. As there are no "key" changes these other documents with minor adjustments will not be listed.

2. Further documentation about the GPPA's approach to evaluating your CPD program to respond to changing needs and requirements.

To afford a better understanding of MDPAC/GPPA's progression in this matter, first find below, the answer to this question in our 2012 submission:

The CPD program will be evaluated by the Membership Committee and the Professional Development Committee on an ongoing basis and formally every 2 years. At the time of the evaluation the Committee will use the following criteria to review the components of the Program:

1. Number and type of learning activities to maintain membership, compare CPD program with other programs i.e. Royal College and College of Family Practice, including reviewing changes to other programs and new developments in CPD in general.
2. Assess success of members meeting the established criteria.
3. Consider feedback from the Membership regarding any difficulties with the reporting system, meeting criteria etc.
4. Review information from random audits of Membership.
5. Evaluate compliance with the CPD program, for example, how many members reporting according to organizational guidelines, fulfilling criteria, maintaining membership status.
6. The Committees will monitor the types of learning activities being reported and how many are referred for more specific consideration i.e. Membership Committee has questioned the relevance of a particular learning activity.
7. Review and modify as necessary; the organizations, institutes and other providers of CPD for inclusion as accredited.

With regards to evaluating our CPD program in response to changing needs and requirements, the Professional Development Committee (PDC) is the primary committee tasked with constructing and evaluating MDPAC/GPPA's CPD program.

The evaluation arm involves utilizing a number of pertinent information resources about current elements and emerging trends in the CPD programs of the RCPSC and the CFPC. We attend the National Accreditation Conference (NAC). And we also look at the equivalent matters in the Canadian Psychological Association, the College of Psychologists of Ontario and the new College of Registered Psychotherapists of Ontario (CRPO). From these sources the PDC is also developing the policies and procedures regarding potential Industry Bias in alignment with the new National Standards. All in-house CPD providers will be informed about, and necessarily be in compliance with these policies and procedures.

The PDC is developing the policies and procedures related to "supervision". (Please note the term "supervision", in matters of psychiatry and psychotherapy is not related at all to matters of remediation.) Supervision is a time-honoured CPD activity, common to all psychotherapies. The term "supervision" refers to a process wherein a psychotherapist receives advice and mentoring on clinical cases he/she is currently engaged in, from an experienced mentor. The process involves enquiry, learning and feedback from that learning. Formalizing the policies and procedures on supervision is an example of our alignment with the trend toward more and more of the CPD credits falling within the Self-Assessment category of the RCPSC and the CFPC, all of which is underpinned by evidence-informed education theory.

The PDC is also the committee responsible for constructing the association's policies and procedures for integrating the CanMEDS Guidelines into the overall CPD program. (This is a work in progress for all specialty areas of medicine in Canada as evidenced by a workshop in the pending NAC8 on integrating CanMEDS into CPD programs.)

The PDC is the committee representing MDPAC/GPPA at the NAC events. The important CPD issues at NAC extend beyond accreditation matters. Association attendees do a pre-conference review and analysis of the conference's workshops, in order to discern which ones to attend based on the relevance for MDPAC/GPPA CPD evolution. Summaries of the workshops and plenaries are brought back to the PDC for consideration on three matters regarding the association's CPD program:

1. What are we doing right?
2. What are we missing and need to add?
3. How do we go from here to there?

The final arbiter of the process and content of our CPD Program evaluation is the 12 member Board of Directors. All the results of the activities of the PDC on these matters are sent to the Board as draft proposals for vetting, and amendments (if necessary), before formal approval.

3. An update on the implementation of the GPPA's audit policy, including statistics from 2015/2016 if available.

The MDPAC/GPPA now has a well-defined audit policy. Policy 3.1.A.vi.e (Appendix L).

The first audit was carried out in the fall of 2015, for the year Oct 1st 2014 to Sept 30th 2015. Audits will be carried out annually for the previous year. Members had been given notice that they should retain evidence of all their educational activities, and had been told which documents would be required for proof of each activity, Policy 3.1.A.vi.e.iii (Appendix L).

In mid-November, after the membership renewals had been processed, the members using the MDPAC/GPPA as their pathway were assigned numbers according to their place on the alphabetical list. It was decided that 5% of the members who are using the MDPAC/GGPA as the Third Pathway should be audited, which represented 8 members.

Random numbers were generated using the website random.org. The members corresponding to these numbers on the list were audited. This method is explained in the Policy 3.1.A.vi.e.i (Appendix L), members chosen at random, method.

The members chosen were asked to supply the relevant documentation for the first CE activity and first CCI activity of each month of the previous year up to a maximum of 10 items. Self- directed CE was not audited, see Policy 3.1.A.vi.e.ii (Appendix L), Method used to select items to be audited.

The audited members were given a deadline for submission of the documents of February 28th 2016, and were asked to send the documents to the MDPAC/GPPA office by mail, fax, or e-mail with scanned document.

Members of the Committee reviewed the documents they received and filled in a form, see Policy 3.1.A.vi.e.iv (Appendix L), form for completion of audit.

All of the members except one supplied all the required documents and received an acknowledging letter. One member failed to supply the necessary documents and was notified that another audit would be carried out 2015-2016. The response was to resign from the MDPAC/GPPA.

4. Answer to Question 4 "Further documentation of any processes to follow up with members who are not compliant with the organization's requirements (Criterion #8)".

The organization has developed a well-defined policy for members who use the MDPAC/GPPA as their reporting pathway and have insufficient credits at the end of the cycle. A copy of the policy is Policy 3.1.A.vii(b); "Insufficient CE/CCI – Clinical CPSO/CPD Members and Certificant and Mentor members using the MDPAC/GPPA as the pathway for CPSO" (Appendix M).

For example, on or around October 1st, 2017 at the end of the 3-year cycle, ending September 30th 2017, the members with insufficient credits will be sent a registered letter, to inform them of the insufficiency, and that they have until November 15th, 2017 to enter their credits into the system. It will also warn them of the consequences if they do not.

After November 15th 2017, remaining members with insufficient credits for the 3-year cycle ending on September 30th 2017, will be informed of the following requirements:

For the first year of the next cycle (e.g. for the year, October 1, 2017 to September 30, 2018) the member will be required to :

a) enter a minimum of 25 hours of any combination of CE and CCI, (the "normal" minimum requirements),

plus,

b) the member is required to make up any deficient hours from the three-year cycle ending on September 30th 2017. The full requirement is 25 hours of CE and 25 hours of CCI per year.

The member will be required to outline a plan to ensure that he/she will have sufficient credits for the cycle ending on September 30, 2020. The plan needs to be received by January 31st 2018.

These members' progress will be reviewed at 6-month intervals over the 3-year cycle, October 1st 2017 to September 30th 2020. If they are not managing to fulfill the requirements or are not following their plan, they will be reminded by e-mail.

We have obtained consent from each of the members using MDPAC/GPPA as the Third Pathway, to give information to the CPSO if it is requested.

The last cycle ended September 30, 2014. They were given until November 15th to enter all the credits. 21 members (some using MDPAC/GPPA as their pathway) had insufficient credits.

Follow-up of these shows the following:

- 5 said they are not using MDPAC as their pathway
- 4 have retired
- 1 has a Leave of Absence
- 1 is living in USA
- 6 have not renewed membership (reason unknown)
- 4 sent in a plan and/or have made up the deficit

5. The GPPA's plans for ensuring the future sustainability of the CPD system.

a. Number of members: In 2012 our members was 225 and in 2016 is 300, which is a 33% increase in membership.

b. Organization's budget: The operational cost is $115,000.00 per year but there is usually about $200,000.00 in the bank.

Revenue

1. There are membership fees to join and to renew membership each year. .
2. There is a fee for Educational Activities provided by the Education and Conference Committees and the policy is for these activities to be "cost neutral" with the fees covering the expenses. On occasion there is revenue when the fees are more than the expenses
3. Recently there has been the implementation of a charge for the application by Education Content Providers seeking MDPAC Accredited status. .

c. Describe staff and Committee roles, responsibilities and expertise to promote evaluation and innovation.

Staff:

i. We have a Professional Association Manager with whom we have a contract to administer the association's affairs. This arrangement is unchanged from 2012 and is as follows:

Responsibilities:

1. Renewal of membership including sending out of notices, registering the renewals;
2. In-putting membership information for Clinical, Clinical CPSO/CPD, Certificant and Mentor members into the web-application for reporting educational credits;
3. Financial management to include collection of membership fees, the payment of the bills;
4. Up-dating information on the website;
5. Desk-top publishing GP Psychotherapist Journal, including sending out the journal and managing advertising.
6. Conference management.
7. Management of educational activities.

ii. We have hired a new member of staff to assist in the clerical duties involved in assessing submissions from organizations for accreditation of their educational activities by our association.

Committees: There is a Board of Directors, which has 12 directors, to which the various committees report on a regular basis. The committees were listed in the original application and the Terms of Reference for each were given at that time.

Conference Committee - 7 members and Association Manager as Secretary
CPSO/CPD Committee - 4 Members
Education Committee - 4 members
Education sub-Committees Retreat
Committee – 7 members
Core Essentials Primary Medical Psychotherapy Committee - 7 members
Finance Committee - Treasurer and 2 members and Association Manager drafts the cheques, deposits money and manages the financial records
Journal Committee - Editor and 5 members
Listserv Committee - Web Master and 2 members (the Association Manager adds members to the Listserv)
Membership Committee - 9 members
Outreach Committee - 8 members
Professional Development Committee - has 5 members
Professional Development - Sub-Committees:
Certificant review Sub-Committee - 5 members,
Mentor Review Sub-Committee - none at present
Accreditation Sub-Committee - 2 members and a paid contract-administrative assistant.

Outreach

Booths - Goals of exhibiting at medical conferences and trade shows

1. To let Family Doctors know about our organization being there to support them in their efforts to do psychotherapy as needed with their patients. It is known that 1 in 5 patients seen in any day at the Family Doctor's office have psychological or psychiatric issues. Treating these on an "as needed basis" can greatly improve their health.
2. Also there are Physicians, Family doctors and Specialists, wishing to improve their Psychotherapeutic Skills in order "to be there" for their patients and we can definitely assist these.
3. We are also reaching out to Psychiatrists and we do have Psychiatrists who are members.
4. Once they know about the MDPAC/GPPA there are physicians who join the organization.

Booths so far

2012 - At the Family Medicine Form (FMF) of the College of Family Physicians - Toronto. 2013 - At Primary Care Conference - Toronto (FMF was in Vancouver)
2014 - At the Family Medicine Form (FMF) of the College of Family Physicians - Toronto.
- At Primary Care Conference - Toronto
2015 - At the Family Medicine Form (FMF) of the College of Family Physicians - Toronto.
- At Primary Care Conference - Toronto
2016 - At Primary Care Conference - Toronto
- booked for Canadian Psychiatric Association Annual Conference
Toronto, September 22 - 24, 2016

Summary The committees are staffed by volunteers at operational capacity and these volunteers are active, committed and work very well. Also 2 new policies (see Appendix J and K) ensure that when the travel to the meeting has been approved by the Board, that the registration costs, travel expenses and the accommodation will be refunded to the member.

6. If and how the GPPA plans to incorporate CanMEDS 2015 into its CPD program, including consideration of roles outside the Medical Expert role.

MDPAC/GPPA views the CanMEDS Guidelines as an exciting addition to CPD and its trending developments.

We are greatly encouraged that the authors of the document explicitly expect specialties in medicine to appropriate the 7 Roles and the related competencies into their practice specificity.

To fully achieve this aim MDPAC/GPPA has set about consulting with a variety of sources of information. We solicited information by way of an association-wide survey of our membership using the principles of needs-based and target-audience. We received presentations from Dr. Campbell (RCPSC) and Dr. Mueser (CFPC) on their respective CPD programs. Their presentations helped inform us of the principles, values and mechanisms necessary for a contemporary CPD program.

As a result of those presentations, and the explicit expectations of the CanMEDS authors, MDPAC/GPPA set about constructing the necessary framework to achieve MDPAC/GPPA- based CPD that will integrate the profession-wide CanMEDS Guidelines.

By explicitly identifying who we are as physician psychotherapy providers, we are able to construct our education principles and values with an eye to the education principles and values shared across the profession as a whole, - e.g. needs-based, life-long-learning etc.-, and those education principles and values that are MDPAC/GPPA-psychotherapy specific, - e.g. Theoretical Pluralism, Continuing Collegial Interaction, etc.

From this base we are able to utilize the CanMEDS Guidelines to expand our CE categories as its authors expected/wanted.

The PDC of MDPAC is well aware that the CanMEDS Guidelines is more than a guide to CE category expansion, it is also a pedagogic tool. We plan to use that fact.

In the construction of the procedures and mechanisms that will be involved in implementing the CE category expansion, we plan to have the member (submitting CPD activity into our tracking program), list (from a drop-down menu) what/which CanMEDS Role(s) the member deems their submitted activity falls under. We understand that this act of reflection, evaluation and determination/judgement facilitates and augments learning.

We will necessarily have an education campaign informing our members of the new definition of physician as outlined in CanMEDS. An excellent summary document itemizing how CanMEDS relates to MDPAC/GPPA has already been drafted.

The general way in which MDPAC/GPPA will integrally utilize the CanMEDS Guidelines for CE category expansion involves striking a balance between a “cycle's” credit minimums under the Medical Expert role, (thus requiring some amount of yearly CPD activity to be in psychotherapy, psychiatry and mental health content), and CPD activities in any of the other six roles.

At present the implementation procedures are being constructed with an eye to the sustainability issue also. MDPAC/GPPA plans to put the onus on the member submitting their CE credits into the tracking program, to identify and explain their reasons for claiming their activity “fits” the chosen CanMEDS role(s). This approach spares the committee and its members tasked with vetting the submissions from that work.

The intended use of a broad interpretative framework vs. an enormous and detailed list of acceptable CE activities (under any one of the six other roles), precludes the necessity to perform endless formal Board-approved revisions/additions to the list. This approach we hold, further reinforces members' reflection (and therefore learning), and further addresses the sustainability issue.

CanMEDS Guidelines informed CE Category expansion policy will involve consideration of such detailed issues as the ratio of time spent on particular types of acceptable CE activity (for example formal research activities [Scholar Role], or writing activities [also Scholar Role], and the hours being credited. We foresee the very act of association policy construction will likely be granted CE credits under the Health Advocate role, but that this activity will also be subject to a ratio of credits to the time spent.

While MDPAC/GPPA CPD policies and procedures remains a work in progress, this is in keeping with the philosophy of life-long-learning. The work that is being done by MDPAC/GPPA in relation to the evolution of Medical Psychotherapy CPD, parallels that of the other two tracking organizations and is congruent with the CanMEDS Guidelines.

7. Any anticipated trends in CPD (including upcoming changes to CFPC's Maintenance of Competence (MOC) program), and how the GPPA will address it.

Our CPD system is a work in progress. In many ways, it is similar to that of the RCPSC in the early 2000's, before they collapsed multiple credit Sections into their present system of 3 Sections (Group Learning, Self-Learning and Assessment), which the CFPC adopted at the end of June, 2016. We presently have 2 main sections (Continuing Education and Continuing Collegial Interaction) and the former is further subdivided into Group CE with Online Group CE and Self-Directed Continuing Education. Within these sections and subsections, there are different categories of CPD (e.g. supervision, discussion with colleagues, self-learning, formal courses and conferences etc.) Currently, all have the same "weight" (e.g. 1 hour of conference is equal to 1 hour of Online Group CE learning), but preferred CPD activities are encouraged through mandatory maximums and minimums.

The MDPAC/GPPA is aware that the trends in CPD include the following:

1. Assessment (either self-assessment or more formal peer-assessment) as a specific and valued educational activity
2. Needs-based learning as being superior to passive learning
3. Awareness of the potential of Industry bias in CPD
4. Movement away from limited maximums towards mandatory minimums, so that members feel all their CPD credits are counted (but that preferred activities are still encouraged)

Furthermore, we have already started to address these trends and changes in the following ways:

1. Assessment The MDPAC/GPPA already gives CPD credits for members undergoing Peer Assessment Reviews by provincial licensing agencies. We also encourage Psychotherapy Supervision as a time-honoured way of gaining psychotherapeutic clinical skills, either through formal training or through case consultation. We are currently revising our policies on what constitutes supervision and who is a supervisor, so as to have comparable standards to other organizations who focus on the practice of psychotherapy (e.g. The College of Registered Psychotherapists of Ontario, and the Canadian Psychology Association).

2. Needs-Based Learning For several years, this has been part of our annual conference feedback, namely "What topics would you like to see in future conferences". Also, in the past 2 years we have conducted a formal survey of our membership regarding what they are looking for in terms of CPD and how our organization could be more responsive to their needs. This is now one of the guiding principles of our organization.

3. Awareness of the Potential for Industry Bias in CPD While the educational activities that the MDPAC/GPPA accredits rarely involve pharmaceutical companies (usually, they are not interested in psychotherapy), our Professional Development Committee is following the anticipated changes in this area and developing a policy to address industry bias. We continue to be abreast of this and other issues by accepting the invitation to send representatives each year to the National Accreditation Conference.

4. Movement Away from Mandatory Maximums Towards Mandatory Minimums This trend may be more complicated for the MDPAC/GPPA to implement, as it would involve a complete overhaul of our CPD tracking software. Nevertheless, it is not impossible and we definitely will be looking into it.

APPENDIX A

MDPAC BYLAWS
Approved by Members: May 23, 2014

A by law relating generally to the conduct of the affairs of

MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
(the "Corporation")

TABLE OF CONTENTS

A by-law relating generally to the conduct of the affairs of
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
(the "Corporation")
BE IT ENACTED as a by-law of the Corporation as follows:

ARTICLE I

INTERPRETATION

1.1 Definitions. In this by-law and all other by-laws and resolutions of the Corporation, unless the context otherwise requires:

- "Act" means the Canada Not for profit Corporations Act S.C. 2009, c.23, including the Regulations made pursuant to the Act, and any statute or regulations that may be substituted therefor, as amended from time to time;
- "Articles" means the original or restated articles of incorporation or articles of amendment, amalgamation, continuance, reorganization, arrangement or revival of the Corporation;
- "Board" means the board of Directors of the Corporation;
- "By-Law" means this by-law and all other by-laws of the Corporation as amended and which are, from time to time, in force and effect;
- "Director" means a member of the Board;
- "Meeting of Members" includes an annual Meeting of Members and a Special Meeting of Members;
- "Member" means a member of the Corporation, namely Voting Members and Non Voting Members, provided that where references are made to "Members" in this by law in respect of meetings of Members and votes by Members, the reference shall be only to that class or classes of Members entitled to receive notice of, attend and vote at such meeting or vote on such matters;
- "Ordinary Resolution" means a resolution passed by a majority of the votes cast on that resolution;
- "Regulations" means the regulations made under the Act, as amended, restated or in effect from time to time;
- "special business" has the meaning set out in section 4.2;
- "Special Meeting of Members" means a special meeting of all Members entitled to vote at an annual Meeting of Members and a meeting of any class or classes of Members entitled to vote on the question at issue; and
- "Special Resolution" means a resolution passed by not less than two thirds (2/3) of the votes cast on that resolution and if a class vote is required, shall mean a resolution passed by not less than two-thirds (2/3) of the votes cast on that resolution by each class that is entitled to vote.

1.2 Interpretation. In the interpretation of this By-Law, unless the context otherwise requires, the following rules shall apply:

(a) except where specifically defined in this By-Law, words, terms and expressions appearing in this By-Law, shall have the meaning ascribed to them under the Act;
(b) words importing the singular number only shall include the plural and vice versa;
(c) the word "person" shall mean an individual, body corporate, a partnership, a trust, a joint venture or an unincorporated association or organization;
(d) the headings used in the By-Law are inserted for reference purposes only and are not to be considered or taken into account in construing the terms or provisions of the By-Law or to be deemed in any way to clarify, modify or explain the effect of any such terms or provisions; and

(e) except where specifically stated otherwise, references to actions being taken "in writing" or similar terms shall include electronic communication and references to "address" or similar terms shall include e mail address. It is the intent of the Corporation to use electronic communication whenever possible.

ARTICLE II

GENERAL

2.1 Registered Office. The registered office of the Corporation shall be situated in Newmarket, Ontario or as otherwise set by the Board.

2.2 Corporate Seal. The Corporation may, but need not, have a corporate seal. If adopted, the seal shall be in the form approved from time to time by the Board and the Secretary of the Corporation shall be the custodian of the corporate seal.

2.3 Fiscal Year. The fiscal year of the Corporation shall end on December 31 of each year or as otherwise set by the Board.

2.4 Execution of Documents. Deeds, transfers, assignments, contracts, obligations and other documents and instruments ("Documents") in writing requiring execution by the Corporation may be signed by two (2) individuals, one of whom holds the office of Chair of the Board, President, or Director and the other of whom holds one of those offices or the office of Secretary or Treasurer or any other office created by By-Law or the Board. The Board may also from time to time direct the manner in which and the person or persons by whom Documents generally and/or a particular Document or type of Document shall be executed. Any person authorized to sign any Document may affix the corporate seal to the Document.

2.5 Banking. The banking business of the Corporation shall be transacted at such bank, trust company or other firm or corporation carrying on a banking business in Canada or elsewhere as the Board may designate, appoint or authorize from time to time by resolution. The banking business or any part of it shall be transacted by an officer or officers of the Corporation and/or other persons as the Board may by resolution from time to time designate, direct or authorize.

2.6 Invalidity of any Provisions of this By-Law. The invalidity or unenforceability of any provision of this By-Law shall not affect the validity or enforceability of the remaining provisions of this By-Law.

2.7 Minutes – Unless otherwise required by the Act, the minutes of meetings of the Board or any committee and any resolutions passed by them shall not be available to the membership at large but shall be made available to Directors and committee members upon request by such individuals to the Secretary.

ARTICLE III

MEMBERS

3.1 Entitlement. Membership in the Corporation shall be available only to persons interested in furthering the Corporation's purposes and who have applied for and been accepted into membership in the Corporation by resolution of the Board or in such other manner as may be determined by the Board. The Board may set criteria for membership which may include maintenance of professional competence requirements.

3.2 Membership Conditions. Subject to the Articles, there shall be two (2) classes of Members in the Corporation, namely, voting and non voting.

Voting Members

1. Voting membership shall be available to persons who have applied for, meet the criteria for and have been accepted for Voting membership and who have paid the applicable annual fee.
2. Unless otherwise required by the Act, a Voting Member shall be entitled to receive notice of, attend and vote at all meetings of the Members of the Corporation. Each Voting Member shall be entitled to one (1) vote at all such meetings. Each Voting Member may participate on any committee if so appointed by the Board.

Non Voting Members

1. Non voting membership shall be available to persons who have applied for, meet the criteria for and have been accepted for non voting membership and who have paid the applicable annual fee.
2. Unless otherwise required by the Act, Non voting Members shall not be entitled to receive notice of, attend or vote at meetings of Members and may not participate on any committee of the Corporation and any references in this By law to Members having such rights shall be to Voting Members.

3.3 Termination of Membership. The rights of a Member lapse and cease to exist when the membership terminates for any of the following reasons:

(a) the Member dies, resigns or, in the case of a corporation, is dissolved;
(b) the Member is expelled or the Member's membership is otherwise terminated in accordance with the Articles or this By-Law;
(c) the Member's term of membership expires;
(d) the Member fails to pay dues or fees in accordance with section 3.6;
(e) the Member fails to meet the criteria set by the Board for continued membership from time to time; or
(f) the Corporation is liquidated or dissolved pursuant to the Act.

Subject to the Articles, upon any termination of membership, the rights of the Member, including any rights in the property of the Corporation, automatically cease to exist. No membership due will be returned to a previous Member upon termination of such Member's membership.

3.4 Resignation. Any Member may resign as a Member by delivering a written resignation to the Chair of the Board or Secretary, in which case such resignation shall be effective from the date specified in the resignation. A Member shall remain liable for payment of any membership dues which may become payable by the Member to the Corporation prior to such resignation.

3.5 Revocation or Suspension of Member. Any Member may have their membership revoked or suspended with or without conditions by the Board if such Member is found to have been:

(i) convicted in Canada of an indictable or offence, or elsewhere of an offence that, if committed in Canada, would be an indictable offence, upon proof of such conviction;
(ii) suspended by a medical licensing authority;
(iii) erased from the medical register of the province in which the member was licensed to practice;
(iv) found guilty, after a hearing by the Executive Committee, whose decision has been confirmed by the Board, of misconduct in a professional respect, of conduct unbecoming a medical practitioner, of failing to practise a standard of medicine acceptable to the Corporation, or of incompetence to a degree warranting expulsion.

Where a Member has their membership revoked or suspended:

(i) such Member shall surrender to the Secretary or designate their membership in the Corporation on demand of the Board; and
(ii) when such terms and conditions as the Board may impose have been satisfied, the Member may apply to the Board to have his membership restored.

3.6 Membership Dues. The Board may require Members to make an annual contribution or pay annual dues or fees and may determine the manner in which the contribution is to be made or the dues or fees are to be paid. Members shall be notified in writing of the membership contribution or dues or fees at any time payable by them. Contributions, fees or dues may vary within a membership class. If membership contributions, dues or fees are levied by the Board, the membership of any Member who is in arrears may be terminated by or under the authority of the Board if such arrears are not paid within a designated time. If such arrears are not paid by such designated time the Board may pass a resolution authorizing the removal of such Member from the register of Members of the Corporation and thereupon such person shall cease to be a Member of the Corporation. Any such Member may re-apply for membership in the Corporation, which re-application will require the payment of any outstanding contribution, dues or fees.

ARTICLE IV

MEETINGS OF MEMBERS

4.1 Place of Meetings. Meetings of the Members may be held at any place within Canada determined by the Board or, if all of the Members entitled to vote at such meeting so agree,outside Canada.

4.2 Annual Meetings. The Board shall call an annual meeting not later than fifteen (15) months after the last preceding annual meeting but not later than six (6) months after the end of the Corporation's preceding financial year. The Board shall call an annual Meeting of Members for the purpose of:

(a) considering the financial statements and reports of the Corporation required by the Act to be presented at the meeting;
(b) electing Directors;
(c) appointing an auditor, if required under Part 12 of the Act; and
(d) transacting such other business as may properly be brought before the meeting or is required under the Act.

Any other matters of business shall constitute special business and a Special Meeting of Members will need to be held.

4.3 Special Meetings. The Board may at any time call a Special Meeting of Members for the transaction of any business which may properly be brought before the Members.

4.4 Notice of Meetings. Notice of the time and place of a Meeting of Members shall be sent to the following:

(a) to each Member entitled to vote at the meeting (which may be determined in accordance with any record date fixed by the Board or failing which, in accordance with the Act);
(b) to each Director; and
(c) to the auditor of the Corporation.

A notice shall be provided at least twenty-one (21) days prior to the meeting. A notice shall be provided in accordance with the requirements of Article XII of this By-Law and shall, subject to the Act, include any proposal submitted to the Corporation by a Member. Notice of a Meeting of Members at which special business is to be transacted shall state the nature of that business in sufficient detail to permit the Member to form a reasoned judgment on the business and provide the text of any Special Resolution or By-Law to be submitted to the meeting.

4.5 Waiving Notice. A person entitled to notice of a Meeting of Members may in any manner and at any time waive notice of a Meeting of Members, and attendance of any such person at a Meeting of Members is a waiver of notice of the meeting, except where such person attends a meeting for the express purpose of objecting to the transaction of any business on the grounds that the meeting is not lawfully called.

4.6 Persons Entitled to be Present. The only persons entitled to be present at a Meeting of Members shall be those entitled to vote thereat, the Directors and auditor of the Corporation and others who, although not entitled to vote, are entitled or required under any provision of the Act, the Articles or the By- Laws to be present at the meeting. Any other person may be admitted only in the invitation of the chair of the meeting or with consent of the meeting.

4.7 Chair of the Meeting. The chair of any meeting of Members shall be the first mentioned of such of the following officers as have been appointed and who is present at the meeting: Chair of the Board or the President. If no such officer is present within fifteen (15) minutes from the time fixed for holding the meeting, the persons present and entitled to vote shall choose one of their number to be chair. If the Secretary of the Corporation is absent, the chair shall appoint some person, who need not be a Member, to act as Secretary of the Meeting. If desired, one or more scrutineers, who need not be Members, may be appointed by a resolution or by the chair with the consent of the meeting.

4.8 Quorum. A quorum at any meeting of the Members (unless a greater number of Members are required to be present by the Act) shall be twelve (12) Members. If a quorum is present at the opening of a Meeting of Members, the Members present may proceed with the business of the meeting even if a quorum is not present throughout the meeting.

4.9 Participation at Meetings by Telephone or Electronic Means. Members may not participate in meetings using telephonic, electronic or other communications means.

4.10 Adjournment. The chair of any meeting may, with the consent of the meeting, adjourn the same from time to time to a fixed time and place and no notice of such adjournment need be given to the Members provided the adjourned meeting takes place within thirty one (31) days of the original meeting. Any business may be brought before or dealt with at any adjourned meeting which might have been brought before or dealt with at the original meeting in accordance with the notice calling the same.

4.11 Votes to Govern. Other than as otherwise required by the Act or this By-Law, all questions proposed for consideration of the Members shall be determined by Ordinary Resolution of the Members. If a Member, the chair may vote at first instance and, in the event there is an equality of votes, the chair shall have a second or casting vote.

4.12 Show of Hands. Except where a ballot is demanded, voting on any question proposed for consideration at a Meeting of Members shall be by show of hands, and a declaration by the chair of the meeting as to whether or not the question or motion has been carried and an entry to that effect in the minutes of the meeting shall, in the absence of evidence to the contrary, be evidence of the fact without proof of the number or proportion of the votes recorded in favour of or against the motion.

4.13 Ballots. For any question proposed for consideration at a Meeting of Members, either before or after a vote by show of hands has been taken, the chair of the meeting, or any Member may demand a ballot, in which case the ballot shall be taken in such manner as the chair directs and the decision of the Members on the question shall be determined by the result of such ballot.

4.14 Annual Financial Statements. The Corporation may, instead of sending copies of the annual financial statements and other documents referred to in subsection 172(1) (Annual Financial Statements) of the Act to the Members, publish a notice to its Members stating that the annual financial statements and documents provided in subsection 172(1) are available at the registered office of the Corporation and any Member may, on request, obtain a copy free of charge at the registered office or by prepaid mail.

ARTICLE V

DIRECTORS

5.1 Powers. The Board shall manage or supervise the management of the activities and affairs of the Corporation.

5.2 Number. Until changed in accordance with the Act, the Board shall consist of a minimum of three (3) and a maximum of twelve (12) Directors. The Board shall be comprised of the fixed number of Directors as determined from time to time by the Members by Ordinary Resolution or, if the Ordinary Resolution empowers the Directors to determine the number, by resolution of the Board. No decrease in the number of Directors shall shorten the term of an incumbent Director.

5.3 Qualifications. The following individuals are disqualified from being a Director of the Corporation:
(a) anyone who is less than 18 years of age;
(b) anyone who has been declared incapable by a court in Canada or in another country;
(c) anyone who has the status of bankrupt; and
(d) anyone who has not been a Voting Member for at least one (1) year.

5.4 Election and Term. The Members shall elect by Ordinary Resolution, at each annual meeting at which an election of Directors is required, six (6) Directors to hold office for a term of two (2) years or until a successor is elected, for a term no longer than four (4) years. Not all Directors elected at a Meeting of Members need to hold office for the same term. A Director not elected for an expressly stated term ceases to hold office at the close of the first annual Meeting of Members following his/her election, but, if qualified, is eligible for re election. If Directors are not elected at a Meeting of Members, the incumbent Directors continue in office until their successors are elected. The maximum number of successive terms served by any Director shall be three (3) terms. Any Director may be re-elected subsequently, provided that a two (2) year period has elapsed since his or her previous term as a Director.
As set out in the Articles, the Directors may appoint additional directors to hold office until the next annual meeting of Members, but no more than one third of the total number of directors appointed by the Members at the Members Meeting may be appointed.

5.5 Consent. A Director who is elected or appointed must consent to hold office as a Director:
(a) if present at the meeting at which the election or appointment takes place, by not refusing to hold office,
(b) if not present at the meeting at which the election or appointment takes place, by either:
(i) consenting to hold office in writing before the election or appointment takes place or within ten (10) days; or
(ii) by acting as a Director after such person's election or appointment.

5.6 Vacation of Office. A Director ceases to hold office when the Director dies, resigns, is removed from office by the Members, or becomes disqualified to serve as Director.

5.7 Resignation. A Director may resign from office by giving a written resignation to the Corporation and such resignation becomes effective when received by the Corporation or at the time specified in the resignation, whichever is later.

5.8 Removal. The Members may, by Ordinary Resolution passed at a Special Meeting of Members, remove any Director from office before the expiration of the Director's term and may elect a qualified individual to fill the resulting vacancy for the remainder of the term of the Director so removed, failing which such vacancy may be filled by the Board. Notwithstanding the foregoing, a Director elected by a class or group of Members that has an exclusive right to elect the Director may only be removed by an Ordinary Resolution of those Members.

A Director shall not be entitled to submit a written statement giving reasons for resigning or for opposing the removal or replacement of the Director if a meeting is called for that purpose.

5.9 Vacancies. Subject to Section 5.8, a vacancy on the Board may be filled for the remainder of the term by a qualified individual by Ordinary Resolution of the Directors.
Notwithstanding the above, if there is not a quorum of Directors or if a vacancy results from either (a) an increase in the number or change to the minimum or maximum number of Directors provided in the Articles or (b) a failure to elect the number or minimum number of Directors provided in the Articles, the Directors then in office shall call a Special Meeting of Members to fill the vacancy and, if they fail to call a meeting or if there are no Directors then in office, the meeting may be called by any Member. If the Director who is ceasing to hold office was elected by a particular class or group of Members, such vacancy shall only be filled by a vote of the Members of that particular class or group of Members.

5.10 Remuneration and Expenses. The Directors shall serve as such without remuneration and no Directors shall directly or indirectly receive any profit from their position as such. Any Director, officer or employee of the Corporation may receive reimbursement for their expenses incurred on behalf of the Corporation in their respective capacities as a Director, officer or employee.

5.11 Powers of the Board. The Board of the Corporation may, without authorization of the Members:

(a) borrow money on the credit of the Corporation;
(b) issue, reissue, sell, pledge or hypothecate debt obligations of the Corporation;
(c) give a guarantee on behalf of the Corporation;
(d) mortgage, hypothecate, pledge or otherwise create a security interest in all or any property of the Corporation, owned or subsequently acquired, to secure any debt obligation of the Corporation;
(e) authorize expenditures on behalf of the Corporation and delegate, by resolution, to an officer or officers of the Corporation, such authority to such maximum amounts as determined by the Board;
(f) employ and pay salaries to employees on behalf of the Corporation and delegate, by resolution, to an officer or officers of the Corporation such authority; and
(g) for the purpose of furthering the mission of the Corporation, acquire, accept, solicit, or receive legacies, gifts, grants, settlements, bequests, endowments, and donations of any kind whatsoever on behalf of the Corporation.

ARTICLE VI

COMMITTEES AND ADVISORY BODIES

6.1 Delegation. Whenever the Board consists of more than six (6) Directors, the Board may appoint from its members an Executive Committee consisting of not less than three (3) Directors, which Executive Committee shall fix its quorum at a majority of its number and may exercise all the powers of the board, subject to any regulations imposed from time to time by the board and subsection 138(2) of the Act. Notice of the time and place of each meeting of the Executive Committee or other committee meeting of the board shall be given in the manner provided in section 10 to each committee member not less than two (2) days (and not less than fourteen (14) days if sent by mail) before the date of the meeting and such notice need not specify the purpose of or the business to be transacted at the meeting. The Board may by resolution remove any member of the Executive Committee or other committee of the Board and may fill the vacancy created by such removal. Executive Committee members and members of other committees of the board shall serve as such without remuneration. However, committee members shall be entitled to be reimbursed for travelling and other expenses properly incurred by them in attending meetings of committees.

6.2 Other Committees and Advisory Bodies. The Board may from time to time appoint any committee, including a Nominating Committee, or other advisory body, as it deems necessary or

appropriate for such purposes and, subject to the Act, with such powers as the Board shall see fit. Any such committee may formulate its own rules of procedure, subject to such regulations or directions as the Board may from time to time make. Any committee member may be removed by resolution of the Board.

ARTICLE VII

MEETINGS OF DIRECTORS

7.1 Place of Meetings. Meetings of the Board may be held at the registered office of the Corporation or at any other place within or outside of Canada as the Board may determine.

7.2 Calling of Meetings. Meetings of the Board may be called by the Board, the Chair of the Board, the President, or any two (2) Directors.

7.3 Notice of Meeting. Notice of the time and place for the holding of a meeting of the Board shall be given in the manner provided in Article XII of this By-Law to every Director of the Corporation not less than two (2) days before the time when the meeting is to be held. Notice of a meeting shall not be necessary if all of the Directors are present, and none objects to the holding of the meeting, or if those absent have waived notice of or have otherwise signified their consent to the holding of such meeting. Notice of an adjourned meeting is not required if the time and place of the adjourned meeting is announced at the original meeting.

7.4 First Meeting of New Board. Provided that a quorum of Directors is present, a newly elected Board may, without notice, hold its first meeting immediately following the Meeting of Members at which such Board is elected.

7.5 Regular Meetings. The Board may appoint a day or days in any month or months for regular meetings of the Board at a place and hour to be named. A copy of any resolution of the Board fixing the place and time of such regular meetings of the Board shall be sent to each Director immediately after being passed, but no other notice shall be required for any such regular meeting except if Section 136(3) (Notice of Meeting) of the Act requires the purpose thereof or the business to be transacted to be specified in the notice.

7.6 Quorum. A majority of the number of Directors constitutes a quorum at any meeting of the Board. For the purpose of determining quorum, a Director may be present in person, or, if authorized under Section 7.8, by teleconference and/or by other electronic means. A quorum must be maintained throughout the meeting.

7.7 Resolutions in Writing. A resolution in writing, signed by all the Directors entitled to vote on that resolution at a meeting of Directors or of a committee of Directors, shall be as valid as if it had been passed at a meeting of Directors or committee of Directors. A copy of every such resolution in writing shall be kept with the minutes of the proceedings of the Directors or committee ofDirectors.

7.8 Participation at Meeting by Telephone or Electronic Means. A Director may, if all Directors are in agreement and have provided their consent, participate in a meeting of Directors or of a committee of Directors using telephonic, electronic or another communication facility that permits all participants to communicate adequately with each other during the meeting. A Director participating in the meeting by such means shall be deemed for the purposes of the Act to have been present at that meeting.

7.9 Chair of the Meeting. The chair of any meeting of the Board shall be the first mentioned of such of the following officers as have been appointed and who is a Director and is present at the meeting: Chair of the Board or President. If no such officer is present, the Directors who are present shall choose one of their number to chair the meeting.

7.10 Votes to Govern. At all meetings of the Board, every question shall be decided by a majority of the votes cast on the question. Each Director shall have one vote. In case of an equality of votes, the chair shall have a second or casting vote. Directors may not appoint proxies to attend meetings in their stead.

ARTICLE VIII

OFFICERS

8.1 Appointment. The Board may designate the offices of the Corporation, appoint officers on an annual or more frequent basis, specify their duties and delegate to such officers the power to manage the affairs of the Corporation. A Director may be appointed to any office of the Corporation. An officer may, but need not be, a Director unless this By-Law otherwise provides. Two or more offices may be held by the same person.

ARTICLE IX

DESCRIPTION OF OFFICES

9.1 Description of Offices. Unless otherwise specified by the Board, the officers of the Corporation shall have the following duties and powers associated with their positions:

(a) Chair of the Board – The Board may from time to time also appoint a Chair of the Board who shall be a Director. If appointed, the Board may assign to the Chair of the Board any of the powers and duties that are by any provision of this By-Law assigned to the President; and the Chair of the Board shall have such other powers and duties as the Board may specify.
(b) President – The President shall be the chief executive officer and, subject to the authority of the Board, shall have general supervision of the affairs of the Corporation; and shall have such other powers and duties as the Board may specify. The President shall be a Director of the Corporation.
(c) Secretary – The Secretary shall have such powers and duties as the Board may specify including attending and being the secretary of all meetings of the Board.
(d) Treasurer – The Treasurer shall have such powers and duties as the Board may specify. The Treasurer shall be a Director of the Corporation.

The powers and duties of all other officers of the Corporation shall be such as the terms of their engagement call for or the Board or President requires of them. The Board may from time to time and subject to the Act, vary, add to or limit the powers and duties of any officer.

9.2 Vacancy in Office. In the absence of a written agreement to the contrary, the Board may remove, whether for cause or without cause, any officer of the Corporation. Unless so removed, an officer shall hold office until the earlier of:

(a) the officer's successor being appointed;
(b) the officer's resignation;
(c) such officer ceasing to be a Director (if a necessary qualification of appointment); or
(d) such officer's death.

If the office of any officer of the Corporation shall be or become vacant, the Directors may, by resolution, appoint a person to fill such vacancy.

9.3 Remuneration of Officers. The remuneration of all officers appointed by the Board shall be determined in accordance with Section 5.10.

ARTICLE X

CONFLICT OF INTEREST

10.1 Conflict of Interest. Every Director and officer shall comply with the provisions of the Act and any code of conduct in place from time to time, including those with respect to conflict of interest.

ARTICLE XI

PROTECTION OF DIRECTORS, OFFICERS AND OTHERS

11.1 Standard of Care. Every Director and officer of the Corporation, in exercising such person's powers and discharging such person's duties, shall act honestly and in good faith with a view to the best interests of the Corporation and shall exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. Every Director and officer of the Corporation shall comply with the Act, the Regulations, Articles, and By-Law.

11.2 Limitation of Liability. Provided that the standard of care required of the Director or officer under the Act and the By-Law has been satisfied, no Director or officer shall be liable for the acts, receipts, neglects or defaults of any other Director or officer or employee, or for joining in any receipt or other act for conformity, or for any loss, damage or expense happening to the Corporation through the insufficiency or deficiency of title to any property acquired for or on behalf of the Corporation, or for the insufficiency or deficiency of any security in or upon which any of the money of the Corporation shall be invested, or for any loss or damage arising from the bankruptcy, insolvency or tortious acts of any person with whom any of the money, securities or effects of the Corporation shall be deposited, or for any loss occasioned by any error of judgment or oversight on the Director or officer's part, or for any other loss, damage or misfortune which shall happen in the execution of such person's duties of office, unless the same are occasioned by the Director or officer's own wilful neglect or default or otherwise result from the Director or officer's failure to act in accordance with the Act or the Regulations.

11.3 Indemnification of Directors and Officers. The Corporation shall indemnify a Director, an officer of the Corporation, a former Director or officer of the Corporation, or another individual who acts or acted at the Corporation's request as a Director or officer or in a similar capacity of another entity, against all costs, charges and expenses, including an amount paid to settle an action or satisfy a judgment, reasonably incurred by such person in respect of any civil, criminal, administrative, or investigative action or other proceeding in which the individual is involved because of that association with the Corporation or other entity if:

(a) the person acted honestly and in good faith with a view to the best interests of the Corporation or, as the case may be, to the best interests of the other entity for which the individual acted as Director or officer or in a similar capacity at the Corporation's request; and
(b) in the case of a criminal or administrative action or proceeding that is enforced by a monetary penalty, the person had reasonable grounds for believing that the conduct was lawful.

The Corporation may indemnify such person in all such other matters, actions, proceedings and circumstances as may be permitted by the Act or the law. Nothing in this By-Law shall limit the right of any person entitled to indemnity to claim indemnity apart from the provisions of this By-Law.

11.4 Insurance. Subject to the Act, the Corporation may purchase and maintain insurance for the benefit of any person entitled to be indemnified by the Corporation pursuant to Section 11.3 against any liability incurred by the individual in the individual's capacity as a Director or an officer of the Corporation; or in the individual's capacity as a Director or officer, or in a similar capacity, of another entity, if the individual acts or acted in that capacity at the Corporation's request.

11.5 Advances. With respect to the defence by a Director or officer or other individual of any claims, actions, suits or proceedings, whether civil or criminal, for which the Corporation is liable to indemnify a Director or officer pursuant to the terms of the Act, the Board may authorize the Corporation to advance to the Director or officer or other individual such funds as may be reasonably necessary for the defence of such claims, actions, suits or proceedings upon written notice by the Director or officer to the Corporation disclosing the particulars of such claims, actions, suits or proceedings and requesting such advance. The Director or officer shall repay the money advanced if the Director or officer does not fulfill the conditions of Section 151(3) of the Act.

ARTICLE XII

NOTICES

12.1 Method of Giving Notices. Any notice (which term includes any communication or document) to be given to a Member, Director, officer, member of a committee of the Board, or the auditor shall be sufficiently given if given by mail, courier or personal delivery, or by an electronic, telephonic, or other communication facility.

A Special Resolution of the Members is required to make any amendment to the By-Law of the Corporation to change the manner of giving notice to Members entitled to vote at a Meeting of Members. A notice so delivered shall be deemed to have been given when it is delivered personally or to the recorded address as aforesaid; a notice so mailed shall be deemed to have been given when deposited in a post office or public letter box; and a notice so sent by any means of electronic or similar communication shall be deemed to have been given when delivered to the appropriate electronic server or equivalent facility. The Secretary may change or cause to be changed the recorded address of any Member, Director, officer, auditor or member of a committee of the Board in accordance with any information believed by the Secretary to be reliable. The declaration by the Secretary that notice has been given pursuant to this By-Law shall be sufficient and conclusive evidence of the giving of such notice. The signature of any Director or officer of the Corporation to any notice or other document to be given by the Corporation may be written, stamped, type written or printed or partly written, stamped, type written or printed.

12.2 Omissions and Errors. The accidental omission to give any notice to any Member, Director, officer, member of a committee of the Board or the auditor, or the non receipt of any notice by any such person where the Corporation has provided notice in accordance with the By-Law, or any error in any notice not affecting its substance, shall not invalidate any action taken at any meeting to which the notice pertained or otherwise founded on such notice.

12.3 Waiver of Notice. Any person entitled to notice may waive or abridge the time for any notice required to be given to such person, and such waiver or abridgement, whether given before or after the meeting or other event of which notice is required to be given shall cure any default in the giving or in the time of such notice, as the case may be. Any such waiver or abridgement shall be in writing.

ARTICLE XIII

BY-LAW AND EFFECTIVE DATE

13.1 By-Law and Effective Date. Subject to the Articles, the Board may, by resolution, make, amend or repeal any By-Law that regulates the activities or affairs of the Corporation. Any such By-Law, amendment or repeal shall be effective from the date of the resolution of the Board until the next Meeting of Members where it may be confirmed, rejected or amended by the Members by Ordinary Resolution. If the By-Law, amendment or repeal is confirmed or confirmed as amended by the Members it remains effective in the form in which it was confirmed. The By-Law, amendment or repeal ceases to have effect

if it is not submitted to the Members at the next Meeting of Members or if it is rejected by the Members at the meeting.

Upon the enactment of this By-Law, all previous by-laws of the Corporation shall be repealed. Such repeal shall not affect the previous operation of any by-law or affect the validity of any act done or right or privilege, obligation, or liability acquired or incurred under, or the validity of any contract or agreement made pursuant to, or the validity of any letters patent of the Corporation obtained pursuant to, any such by-law prior to its repeal. All Directors, officers, and person acting under any by-law so repealed shall continue to act as if appointed under the provisions of this By-Law and all resolutions of the Members and of the Board with continuing effect passed under any repealed by-law shall continue as good and valid except to the extent inconsistent with this By-Law and until amended or repealed.

ENACTED this 14 day of May, 2014..

Catherine Low
Chair, MDPAC

Brian McDermid
President, MDPAC

CONFIRMED by the Members this 23 day of May, 2014.

APPENDIX B

Policy 3.1.A.vi.b - CE/CCI Monitoring

Title	CE/CCI Monitoring
Number	3.1.A.vi.b.
Policy Area	Operations/Services/Membership
Policy Statement	1. Members are required to record their CE/CCI on the web site and the web site records will be reviewed by members of the Membership Committee. Members can view their CPD credits on the website on the Summary page which states their membership category, required credits as well as progress in achieving these credits to date. 2. The MDPAC has a 3-year cycle in which members are to achieve and report all their required CPD. In addition they are required to achieve and report at least one- half of the required CPD credits each year, by the end of the MDPAC reporting year. 3. A new member's credits will be pro-rated to fit into the 3 year cycle. 4. Members of the Membership Committee will review the entered CPD credits and approve or deny as needed. If necessary an email will be sent from the programme to a member to clarify the information in an entry. Failure of the member to respond to the email within 60 days will result in the entry being denied.
Procedure	1. All membership renewal notices will be sent out at the same time, in early September and the renewal invoice will state 3 payment options as follows: Payment received before October 1st - Early bird discount of $50.00. Payment received between October 1st - 31st - usual fee. Payment received after October 31st - fee plus $50.00 penalty 2. At the time of renewal of membership, each member is required to have all their CPD entries up to date. 3. The members of the Membership Committee shall review the records and approve the credits on an ongoing basis according to the allowable CE/CCI rules. 3.A.vi.b.2. Procedure for CE/CCI Monitoring
Responsibility/ Monitoring	Membership Committee
Effective Date	May 27, 2004
Original Date	February 28, 2002
Date Reviewed	March 24, 2005
Date Revised	May 27, 2004 June 24, 2010 June 23, 2016

APPENDIX C

3.1.A.vi.b.2 Procedure for Approving CE/CCI Records

Title	Procedure for Approving CE/CCI Records
Number	3.1.A.vi.b.2
Policy Area	Operations/Services/Membership
Policy Statement	1. In order to ensure consistency and accuracy in the approval process all the members of the Membership Committee will use the same criteria for approving the credits of the members, following the instructions in the Manual for Approvers created for this purpose. 2. The criteria for the allowable credits will be according to the allowable CE/CCI rules as set by PDC with the approval of the Board.
Procedure	Log into gppaoline.ca Click on CE/CCI Put in username and password then click “log in”. Click on “Browse Members” (far right). Identify the name of the member whose record you want to access. Click on “view item list”. Look at the record – date, type of CME, description duration. Check that no duplicates have been made (i.e. 2 identical entries on the same date). Click on “details” to see the specifics of the entry and make sure everything required has been completed and the CME is acceptable. **If the item is not clear or complete under “Details”, scroll down to “Write comment/question here” and when this is completed click on “Submit comment”. This will send an e-mail to the member from the programme, to which they need to respond.** If the item is acceptable, go back to the previous page and Click on “decide”. Then click “approve”, check the number of hours claimed and change if necessary. Then click “submit”. If the item needs to be denied click, “Deny”, then “submit”. You will then be prompted to make an explanation. Once you have typed in your comment, i.e. reason for the “Deny’, click “submit”. For further particulars see Manual for Approvers.
Responsibility/ Monitoring	Membership Committee
Effective Date	January 27, 2011
Original Date	2005
Revised Date	March 22, 2012, June 23, 2016

APPENDIX D

Accreditation Application Form

INSTRUCTIONS
Please attach the program/agenda/flyer for the session if available, as the program will likely include much of the information referred to in the subsequent questions. If detailed information requested in the following questions is specified in the program agenda, please indicate "see program/agenda".

This form is a FILLABLE word form. Please input information into the appropriate fields and SAVE the document to your computer. Then, email the completed document to the GPPA Office at info@gppaonline.ca

NOTE: Please allow 6 weeks for your application to be processed.
Please wait for confirmation of GPPA accreditation before publishing this on your flyer/brochure.

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1. Contact person's information:
Note: the contact person is the person who is submitting the information about the educational activity, to whom any questions about the activity should be directed, for purposes of the accreditation review.

Name: Enter Name
Position: Enter Position
Phone # Enter Telephone and Extension
E-mail address: Enter Email Address

2. Name of Sponsoring Agency:
Enter Name of Sponsoring Agency
Note: this is the name of the organization that is sponsoring or organizing the session and requesting accreditation (e.g., OMA, university, other learning institution, professional organization, hospital, clinic etc.).

Was there a Physician Psychotherapist or Psychiatrist on the organizing committee?
□ Yes □ No

3. Overall Title/ Name of the session (name of the continuing professional development (CPD) session):
Enter Title of Session.

4. Date and time of the CPD session:
Enter Date and Time of Session
Note: The Time is the actual learning time of the session (excluding meals and breaks). If there is time allocated during the session for meals and breaks, the times for the educational sessions and the times for the meals/breaks must be specified.
If this will be a series of sessions, please include all of the dates and times of the sessions.
A series of sessions (both Group CE sessions and CCI sessions) may be approved as a group, for a period not longer than 12 months, as long as all of the required information is provided in this form (or as an attachment).

5. Location of the sessions and type of setting:
Enter Location of Session and Type of setting.
Note: location is the actual location (organization & address) where the session will be held.
Type of setting is the learning environment for the session (e.g., classroom, office etc.).

6. Topics and Presenters: Name and Qualifications of the Presenter/Leader of the session:
Enter Name and Qualifications of Presenter/Leader
NOTE: The topics must be relevant to the practice of GP psychotherapy or Psychiatry.
For a single Group CE session- please include all of the topics and presenters for each topic (if this information is not specified on the attached program agenda). For example, a one hour session would generally have one topic and presenter/leader. A full-day session would typically have several topics with several speakers.
For a series of Group CE sessions- please include the topic(s) and presenter(s) and dates for each session (if this information is not specified on the attached program agenda).
For a series of supervisory sessions, with the same supervisor/leader for all of the sessions, please include the name of the supervisor/ leader for the series.

7. Please confirm that this program is being ethically offered in accordance with the CMA Guidelines for interaction with industry.
These Guidelines can be accessed at http://policybase.cma.ca/dbtw-wpd/Policypdf/PD08-01.pdf
☐ Yes ☐ No
If "no" please explain.
Please explain

8. What are the goals and the learning objectives of the program?
Enter Goals and Learning Objectives of the Program

9. What percentage of the session has been allocated for interaction (i.e., interaction among the participants, interaction between the participants and the speakers, questions of the speakers etc.).
Please indicate % allocated for interaction %

10. Will the participants be asked to complete a program evaluation, and will this information be used to modify and plan future programs? ☐Yes ☐ No
If "no" please explain.
Please explain

11. Will attendance be taken, and will the participants be given confirmation of attendance, for audit purposes? ☐Yes ☐ No
If "no" please explain.
Please explain

12. Type of Credits being sought for the session:

CE-Group (continuing education – group session):
Please specify type of session:
☐ conference; ☐ seminar; ☐ workshop; ☐course;
other teaching session Please specify

CCI (continuing collegial interaction):
Please specify type of activity:
☐ group supervision (e.g., Balint group);
☐ interaction in conjunction with a CE-group session (Note: the CE-group component of the session must be a full day, i.e., 6 hours of approved CE-group credits to obtain an additional 1 hour of CCI credits);
other Please specify

13. ADDITIONAL INFORMATION
Please enter any additional information which would be helpful in the review of this application.

APPENDIX E

Accreditation Application Form – Online Courses

Please note: This form is to be completed for online CPD courses only.

For CPD activities which are attended in-person, or in "real time" (e.g. Skype, or one-time Webinar), please complete the general Accreditation Application form.

INSTRUCTIONS

Please attach the program/agenda/flyer for the online CPD activity if available, as the program will likely include much of the information referred to in the subsequent questions. If detailed information requested in the following questions is specified in the program agenda, please indicate "see program/agenda".

This form is a FILLABLE word form. Please input information into the appropriate fields and SAVE the document to your computer. Then, email the completed document to the GPPA Office at info@gppaonline.ca

NOTE: Please allow 6 weeks for your application to be processed.

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1. Contact person's information:

Note: the contact person is the person who is submitting the information about the online CPD activity, and to whom any questions about the activity should be directed, for purposes of the accreditation review.

Name: Enter Name
Position: Enter Position
Phone # Enter Telephone and Extension
E-mail address: Enter Email Address

2. Name of Sponsoring Agency:

Enter Name of Sponsoring Agency

Note: this is the name of the organization that is sponsoring or organizing the online CPD activity and requesting accreditation (e.g., OMA, university, other learning institution, professional organization, hospital, clinic etc.).

Was there a Physician Psychotherapist or Psychiatrist on the organizing committee?

☐ Yes ☐ No

3. Overall Title/ Name of the Online CPD Activity (course/ module). (name of the continuing professional development (CPD) activity):

Enter Title of CPD Course/ module.

4. Topics and Presenters: Name and Qualifications of the Presenter/Leader of each Module:

Enter Topic as well as Name and Qualifications of Presenter/Leader for each module

NOTE: The topics must be directly relevant to the practice of GP Psychotherapy, Psychiatry or Mental Health.

For a single online module- please include all of the topics and presenters for the module (if this information is not specified on the attached program agenda).

For a series of online modules, or an online course consisting of several modules- please include the topic(s) and presenter(s) for each module (if this information is not specified on the attached program agenda).

5. Please confirm that this online CPD activity is being ethically offered in accordance with the CMA Guidelines for interaction with industry.
□ These Guidelines can be accessed at http://policybase.cma.ca/dbtw-wpd/Policypdf/PD08-01.pdf
□ Yes □ No
If "no" please explain.
Please explain

6. What are the goals and the learning objectives of the overall CPD activity and each of the online modules?
Enter Goals and Learning Objectives of the Activity and Modules.

7. Number of Modules included in the Online CPD activity:_____module(s)
Please note: An online module, or online course which consists of several modules may be approved for a period of not longer than 12 months, as long as all of the required information for each module has been provided in this form (or as an attachment).

8. Please indicate: which of the following activities are included in each module:
□didactic online teaching session or required reading component

□ a videotaped actual or simulated session as a teaching tool for each module.

□ interactive component: please specify: □virtual therapist; □ posting of online questions or comments for other participants to read; □other (please specify) _____

□ Self-assessment activity (quiz/ test) at the end of each module or at the end of the course

9. Amount of time required to complete each module (including all of the activities involved in the module, (listed above):____hour(s)____minute(s)

Amount of time required to complete the complete course (including all of the modules):
____hour(s) _minute(s)

10. What percentage of the session has been allocated for the interactive component of the module (e.g., virtual therapist, posting of comments, other interaction among the participants or between the participants and the presenters etc.). Please indicate % allocated for interaction _%

11. Will the participants be asked to complete a program evaluation, and will this information be used to modify and plan future programs? ☐Yes ☐ No

If "no" please explain.
Please explain

12. What are the criteria for achieving completion of each module?
☐online didactic or required reading component of the session/ module completed.
How will this be determined? _____

☐required reading didactic component of the session/ module completed.
How will this be determined? _____

☐ videotaped actual or simulated session
How will this be determined? _____

☐ interactive component completed.
How will this be determined? _____

☐quiz or test completed.
What is the minimum mark/ percentage required for successful completion of the module?____%

☐other (please specify)_____

13 Will the participants be given confirmation of successful completion for audit purposes? ☐ Yes ☐ No
If "no" please explain.
Please explain

14. Type of Credits being sought for the session:

☐CE-Group (continuing education – approved online learning activity):
Please note: CCI (continuing collegial interaction) credits are not awarded for online learning activities.

15. ADDITIONAL INFORMATION
Please enter any additional information which would be helpful in the review of this application.

APPENDIX F

GPPA ACCREDITATION FORM 3.1.B.i.a.ii (internal use only)

Program Name:	Date:
Sponsoring Agency:	Contact person name:
Contact Phone #:	Contact e-mail:
GPPA Reviewer(s):	

Criterion	Met? Y/N/NK*	Comments
The content of the educational program is relevant to the practice of GP Psychotherapy or Psychiatry.		
The program is being provided by a credible CE provider (recognized providers i.e. University departments, training institutes, College of Family Practice, Royal College, hospitals, OMA, etc.)		
The program is taking place in an appropriate learning environment.		
The program is being ethically offered in accordance with CMA Guidelines for interaction with industry.		
Learning objectives and goals are clearly stated.		
Hours being requested match the program outline excluding meal and refreshment breaks.		
There is opportunity for participants to interact with the speakers and ask questions and this is built in the schedule.		
Is there a GP Psychotherapist or Psychiatrist on the planning committee for the event? This is required for the Royal College and College of Family Practice. We do not make it a requirement but it is encouraged.		
There is a structure to provide evaluation of the program and there is evidence that this is being used to modify and plan future programs.		
Attendance is taken, and participants are given confirmation of attendance, for audit purposes.		

*Y=yes; N=no; NK=not known.

Initial Assessment:

Date of initial assessment:
Outcome of Initial Assessment:
□ a) Approved days = hours of GPPA Group-CE credits per workshop
□ b) Approved for____number of hours of GPPA CCI credits (automatically calculated when GPPA member submits Group CE hours)
□ c) This educational activity comes under the category of GPPA Self-Learning credits
□ d) Additional information is required for review of the accreditation request…"*
* Specify additional information required:

□ e) Not approved for GPPA credits, as it does not meet the current GPPA criteria for accreditation for the following reason(s):
Specify reasons for non-accreditation) :

Contact person_____advised on _____(date)

by_____on behalf of the Accreditation Sub-Committee of the PDC.
Other Comments:
(e.g., Follow-up Issues, Contact person/date, Dates Additional information received etc.):

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* Subsequent Assessment (if additional information was requested after the Initial Assessment):

Date of Subsequent assessment:_____
Outcome of Subsequent Assessment (following receipt of additional information):
□ a) Approved for_____number of hours of GPPA Group-CE credits
□ b) Approved for_____number of hours of GPPA CCI credits
□ c) This educational activity comes under the category of GPPA Self-Learning credits
□ d) Not approved for GPPA credits, as it does not meet the current GPPA criteria for accreditation for the following reason(s):
Specify reasons for non-accreditation) :

Contact person_____advised on_____(date)

by_____on behalf of the Accreditation Sub-Committee of the PDC.
Other Comments:

APPENDIX G

GPPA ACCREDITATION FORM- On-Line courses (internal use only)

Overall Title/ Name of On-Line CPD Activity:	Date:
Sponsoring Agency:	Contact Person Name:
Contact Phone #:	Contact e-mail:
GPPA Reviewer(s):	

Criterion	Met? Y/N/NK*	Comments
The content of the educational program is relevant to the practice of GP Psychotherapy, Psychiatry or Mental Health.		
The program is being provided by a credible CE provider (recognized providers i.e. University departments, training institutes, College of Family Practice, Royal College, hospitals, OMA, etc.)		
The program is being ethically offered in accordance with CMA Guidelines for interaction with industry.		
Learning objectives and goals are clearly stated for each module(s).		
The module(s) includes all of the following: (a) didactic or required reading component; (b) videotaped actual or simulated session as a teaching tool for each module; (c) interactive component ("virtual therapist", posting of on-line comments or other interactive activity) and (d) a self-assessment activity (quiz or test).		
The interactive component consists of no less than 10 % of the estimated time required to complete the module.		
Hours being requested match the estimated time required to complete all of the components of the module(s).		
There is a GP Psychotherapist or Psychiatrist on the planning committee for the event. (This is required for the Royal College and College of Family Practice. We do not make it a requirement but it is encouraged.)		
There is a structure to provide evaluation of the program and there is evidence that this is being used to modify and plan future programs.		
Successful completion of each module requires completion of all of the following: (a) didactic/ required reading component; (b) videotaped actual or simulated session (c) interactive component; (d) passing mark on test/quiz		
Confirmation of successful completion is given to participants for audit purposes.		

*Y=yes; N=no; NK=not known.

Initial Assessment:

Date of initial assessment:
Outcome of Initial Assessment:
□ a) Approved for_____number of hours of GPPA Group-CE credits
□ b) This educational activity comes under the category of GPPA Self-Learningcredits
□ c) Additional information is required for review of the accreditation request…"*
* Specify additional information required: .

□ d) Not approved for GPPA credits, as it does not meet the current GPPA criteria for accreditation for the following reason(s):
Specify reasons for non-accreditation) :

Contact person_____advised on_____(date)

by_____ on behalf of the Accreditation Sub-Committee of the PDC.
Other Comments:

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* Subsequent Assessment (if additional information was requested after the Initial Assessment):

Date of Subsequent assessment:_____
Outcome of Subsequent Assessment (following receipt of additional information):
□ a) Approved for____number of hours of GPPA Group-CE credits (per module)
□ b) This educational activity comes under the category of GPPA Self-Learningcredits
□ c) Not approved for GPPA credits, as it does not meet the current GPPA criteria for accreditationfor the following reason(s):
Specify reasons for non-accreditation) :

Contact person_____advised on_____(date)

by_____on behalf of the Accreditation Sub-Committee of the PDC.
Other Comments

APPENDIX H

Terms of Reference – Core Essentials Committee

Committee Name	Core Essentials in Primary Care Medical Psychotherapy
Number	2.8.A.i.m
Statement of Purpose	To plan and maintain an education program for those doing psychotherapy as part of a medical practice.
Authority	The Committee shall have the power to fix its quorum at not less than a majority of its members, to elect its chair and to regulate its procedure. The powers of the Committee may be exercised by a meeting at which a quorum is present.
Accountability	The Committee shall report to the Education Committee and also directly to the Board. The frequency should be monthly, unless there is nothing to report.
Specific Functions	Planning an Education Program to assist physicians who will be using psychotherapy as part of their medical practice. Carry through this mandate through the following: 1. Drawing up a list of topics for courses to be offered. 2. Qualifying parameters in medical psychotherapy. 3. Use pre-existing courses plus other course materials to develop this course. 4. Seeking other collaborators.
Membership	The Committee should consist of four or more members all of whom shall be members of the GPPA. The Board Liaison shall be an ex officio member of the Committee.
Chair	Term will be for 2 years and can be renewed
Meeting Frequency	The committee shall meet monthly or more often if necessary.
Quorum	Minimum of three members or 50% plus one.
Attendance	Members may attend meetings by telephone/video conference call or in person
Roles and Responsibilities	Co-Chair Roles: 1. Chair will be the contact person for the Committee - Both to be contacted or will pass on to other Co-Chair, if sent to one only 2. Plan the agenda for each meeting together 3. Take turns sending out the notice for the meeting (or one do this each month) 4 Take turns Chairing the meetings. 5. Write the report to the Board (either alternate or one take this role). 6. Write the AGM Report together. Secretary Role: 1. Write the minutes of the meeting and send to the two Co-Chairs for comment before sending them out 2. Let Association Manager know the date and time for the next meeting and ask her to set up the Gotomeeting.
Resources	A budget shall be provided to the Board Treasurer annually for recommendation to the Board.
Approval date	November 26, 2015
Original Date	November 9, 2015
Date Revised	January 28, 2016 May 19, 2016, June 23, 2016

APPENDIX I

Volunteer Recognition Policy

Title	Volunteer Recognition Policy
Number	2.9
Policy Area	Board of Directors
Policy Statement	The policy of the GPPA is to recognize and reward those member who give of their time and expertise to volunteer for the various GPPA Committees.
Procedure	A. In August of each year, the GPPA Association Manager will contact all Committee Chairs to request the following: ● Names of all committee members who have been active September 1 of the previous year ● Verification that these volunteers have attended and actively participated in at least 50% of committee meetings ● A Thank You letter to be sent to each volunteer (one copy, to be reproduced and sent by the Association Manager) B. That each of these committee volunteers receive a letter from the committee chair, and the President of GPPA, and recognition as follows: $50 GPPA Appreciation Coupon (to be used for GPPA membership dues or conference registration fees) Note: The coupon will expire one year after the date of issue. Finance
Responsibility / Monitoring	Committee and Treasurer
Effective Date	June 26, 2014
Original Date	June 26, 2014
Date Reviewed	April 16, 2015
Date Revised	

APPENDIX J
Expenses Policy

Title	Expenses Policy
Number	3.3.F
Policy Area	Operational/Financial
Policy Statement	The GPPA will cover reasonable expenses, including travel costs, accommodation costs and registration fees, for events attended by members of GPPA who are attending at the request of GPPA, and whose attendance has been approved by the Board.
Procedure	A. Where possible, Board approval will be sought prior to the event. A GPPA Event and Travel Expense Application (3.3.F.a) outlining the estimated expenses must be completed with the request for approval. Note: While the estimated expenses are for consideration prior to the event, actual expenses will be reimbursed, as outlined in B and C, below. B. The reasonable expenses to be covered, upon submission of receipts, are as follows: 1. Cost of traveling a. by car pay mileage at $0.50/km (We encourage that where practical and applicable members carpool) b. by plane: economy class c. by train: regular fare, no first class 2. Cost of accommodation For the hotel in which the event is held, or other accommodation up to the cost of the hosting hotel; a receipt must be provided in either case. The nights to be included are the night before the event and the night after, if one day only. If more than one day, then night before, the nights of the events, including the night of the last day. 3. Cost of Meals Cost of meals required during the member's absence from home. Maximum cost each day is $60 including gratuity and taxes. Note, alcoholic beverages will not be covered. 4. Cost of the Event This includes registration, administration and other necessary costs related to the event. 5.. Personal Expenses The GPPA is not responsible for expenses of spouses, entertainment or other items of a personal nature such as laundry, personal telephone calls, in-room and bar charges (including in-room bar). C. Expenses up to $1000 may be paid out by the Association Manager. Total expenses over $1000 for an event will require the Association Manager to consult with the Finance Committee prior to disbursement of the funds; the Finance Committee will consider the disbursements based on previous Board approval. Where Board approval is not adequate for the expenses requested, the Finance Committee will consult with the Board.
Responsibility/ Monitoring	Finance Committee and Treasurer
Effective Date	June 27, 2013
Original Date	June 27, 2013
Date Reviewed	
Date Revised	September 24, 2015

APPENDIX K

Membership Categories and Dues

MDPAC MEMBERSHIP CATEGORIES AND DUES

(i) Associate Member Annual Renewal Fee: by Oct. 1: $170; Oct. 1st -31st : $195; after Oct. 31st : $220.

Criteria: Any physician, who is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics.

Privileges: Journal, copy of Membership Directory and other communications, but no voting rights or committee participation.

(ii) Clinical Member Annual Renewal Fee: by Oct. 1: $170; Oct. 1st -31st : $195; after Oct. 31st :$220.

Criteria: Any physician, who is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics.

Maintenance of Competence (MOCOMP): 12 hours per year or 36 hours over 3 years (October 1, 2014 - September 30, 2017), prorated for newer members) of psychotherapy-related continuing education (CE) and 12 hours per year or 36 hours over 3 years (October 1, 2014-September 30, 2017, prorated for newer members) of Continuing Collegial Interaction (CCI) individual or group professional-support activities (any combination of supervision and other focused peer interaction).

Privileges: Journal, Membership Directory (listing in and a copy) and other communications; membership in professional e-mail discussion group called the Listserv; voting rights and committee participation; reduced registration fees for MDPAC conferences and courses.

(iii) Clinical CPSO/CPD Member (Ontario Only)

Annual Renewal Fee: by Oct. 1: $225; Oct. 1st -31st: $275; after Oct. 31st : $325.

IMPORTANT: A Government regulation mandating Continuing Professional Development (CPD) was passed in Ontario in late July, 2011. This requires that a physician in Ontario must have proof of a required number of educational credits in order to renew their license to practice medicine. CPD credits may be reported via the MDPAC once the appropriate consent form has been signed.

ALSO: The CPSO requires an equivalency with the CFPC and therefore the requirement for this category has been set at that same level i.e. 25 hours of CE and 25 Hours of CCI each year. It is also required that half of these hours be reported each year i.e. 25 hours (any combination of CE/CCI) each year.

Criteria: Any physician, who is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics in Ontario. New Clinical CPSO CPD Membership (in Ontario) requires practicing a minimum of 51% Psychotherapy, Mental Health and/or Addictions.

Maintenance of Competence (MOCOMP): 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017, prorated for newer members) of psychotherapy/psychiatry-related continuing education (CE) and 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017, prorated for newer members) of Continuing Collegial Interaction (CCI) individual or group professional-support activities (any combination of supervision and other focused peer interaction).

Privileges: Journal; for Ontario members, confirmation to the CPSO of educational credits, Membership Directory (listing in and a copy) and other communications; membership in professional e-mail discussion group called the Listserv; voting rights and committee participation; reduced registration fees for MDPAC conferences and courses.

(iv) Certificant (MDPAC(C)): To apply, one must be a Clinical member, dues paid
One-Time Application Fee: $250.00

Annual Renewal Fee: by Oct. 1: $225; Oct. 1st -31st: $275; after Oct. 31st : $325.

Criteria: (Request Certificant Application Package for more details.)

- Qualified clinical member with 200 hours minimum practice experience
- Completion of a short essay describing why you choose to practice psychotherapy
- Completion of 50 hours of personal growth work (individual or group)
- Completion of 100 hours of supervision (individual or peer group/collegial interaction)
- Two references, one of which should be from a colleague familiar with the applicant's psychotherapeutic work
- Attendance at the MDPAC annual (or equivalent intensive psychotherapy) conference in 2 of the 4 years prior to application
- Provision of a curriculum vitae
- Satisfaction of the training criteria from one of the categories listed below:
  - (1) formal training — minimum of 90 hours of MDPAC - approved psychotherapy-related training (with the specified content outlined),
  - (2) practice-eligible training - 1000 hours of paid professional work as a psychotherapist engaged in scheduled focused psychotherapy. This criterion may be time-limited.

MOCOMP: 25 hours psychotherapy/psychiatry-related continuing education (CE) per year or 75 hours over 3 years (October 1, 2014-September 30, 2017), prorated for newer members); and 25 hours per year of Continuing Collegial Interaction (CCI), individual or group professional-support activities (any combination of supervision and other focused peer interaction) or 75 hours over 3 years (October 1, 2014-September 30, 2017), prorated for newer members). It is also required that half of these hours be reported each year i.e. 25 hours (any combination of CE/CCI) each year.

Privileges: Journal, for Ontario members confirmation to the CPSO of educational credits, Membership Directory (listing in and a copy) and other communications; membership in professional e-mail discussion group called the Listserv, reduced registration fees for MDPAC conferences and courses; voting and committee participation; entitlement to use MDPAC(C) after name and other degrees; registration with the organization as a certificant.

(v) Mentor (MDPAC(M)): To apply, one must be a Certificant member

One-Time Application Fee: $250.00

Annual Renewal Fee: by Oct. 1: $225; Oct. 1st -31st: $275; after Oct. 31st : $325.

Criteria: Qualified certificant, with formal comprehensive psychotherapy training in at least one recognized discipline and 2000 hours minimum psychotherapy experience, or 8,000 hours paid psychotherapy with submission of individual training history; 100 hours individual supervision with at least two independent supervisors; successful completion of essay examination and oral interview as determined by the Mentor Subcommittee of the Professional Development Committee; successful completion of MDPAC - approved supervisory training; submission of two satisfactory references, one from a colleague familiar with the applicant's psychotherapeutic work and one from a recent supervisor.

MOCOMP: 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017), prorated for newer members) of psychotherapy/psychiatry -related CE, and 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017), prorated for newer members) of Continuing Collegial Interaction (CCI) individual or group professional-support activities (any combination of supervision and other focused peer interaction). It is also required that half of these hours be reported each year, i.e. 25 hours (any combination of CE/CCI) each year.

Privileges: Journal, for Ontario members confirmation to the CPSO of educational credits, Membership Directory (listing in and a copy) and other communications; membership in professional e-mail discussion group called the Listserv; reduced registration fees for GPPA conferences and courses; voting and committee participation; entitlement to use MDPAC(M) after name and other degrees; registration with the MDPAC as a mentor.

(vi) Honorary Member Annual Renewal Fee: $00.00

This designation may be granted by the Board of Directors in recognition of exemplary contribution to the GPPA, and is for life. There are no academic or practice requirements, no MOCOMP, and no annual fee. Privileges include Journal, copy of Membership Directory and other communications, but not voting or committee membership, although the Honorary Member may be consulted by the Board or GPPA committees from time to time. The current Honorary Members are the surviving founder of the GPPA, Dr. Terry Burrows, Dr. Dianne McGibbon and Dr. Roy Salole.

REDUCED FEE CATEGORIES

(vii) Student Member Annual Renewal Fee: $10.00

Criteria: Medical student enrolled in one of the Faculties of Medicine in a Canadian University or foreign medical graduates enrolled in a formal pre-residency training program through one of the Canadian Faculties of Medicine. Send details of where enrolled and year of study.

Privileges: Journal, copy of Membership Directory and other communications, but no voting rights or committee participation. Reduced registration fees for MDPAC conferences and courses.

(viii) Inactive Member - not working for remuneration in Canada Annual Renewal Fee: $90.00

a) Retired - Criteria: Clinical member, Certificant Member or Mentor, retired from clinical practice. Send letter giving details.
Privileges: Journal, copy of Membership Directory and other communications. Membership in professional e-mail discussion group called the Listserv; committee participation; reduced registration fees for MDPAC conferences and courses. No voting rights.

b) Out of Country - Criteria: Clinical member, Certificant member or Mentor, not practicing in Canada for a
12 month period.
Send letter giving details.
Privileges: Journal and other communications, but no voting rights or committee participation.

c) Totally Disabled Member or on Leave of Absence - Criteria: Clinical member, Clinical CPSO/CPD, Certificant member or Mentor, on full disability (no earned income). Pleaseprovide letter attesting full disability.
Leave of Absence may be for a variety of reasons during which the member has no earned income, give start date.
Privileges: Journal, copy of Membership Directory and other communications. Membership in professional e-mail discussion group called the Listserv; committee participation and voting rights; reduced registration fees for GPPA conferences and courses.

(ix) Mentor Emeritus Annual Renewal Fee: $90.00

Criteria: Mentor Members who are no longer in practice but wish to retain their status to teach and supervise.

MOCOMP: 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017), prorated for newer members) of psychotherapy/psychiatry -related CE, and 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017, prorated for newer members) of Continuing Collegial Interaction (CCI) individual or group professional-support activities (any combination of supervision and other focused peer interaction). It is also required that half of these hours be reported each year, i.e. 25 hours (any combination of CE/CCI) each year.

Privileges: Journal, for Ontario members confirmation to the CPSO of educational credits, Membership Directory (listing in and a copy) and other communications; membership in professional e-mail discussion group called the Listserv; reduced registration fees for GPPA conferences and courses; voting and committee participation; entitlement to use MDPAC(M) after name and other degrees; registration with the MDPAC as a mentor.

(x) Individual Assessment $90.00 or less (decision by the Board)

Criteria: Clinical Member, Certificant Member or Mentor for whom payment of fees will result in undue financial hardship. Please provide letter with respect to your expected earnings from all sources and expenses for the coming year. (Please note you may be requested to provide additional details.)

Privileges: Journal, Membership Directory (listing in and a copy) and other communications. Membership in professional e-mail discussion group called the Listserv; committee participation and voting rights; reduced registration fees for GPPA conferences and courses.

3.1.A.ii.c 2016

APPENDIX L

Audit Policy and Procedure

Title	Audit Policy and Procedure
Number	3.1.A.vi.e
Policy Area	Operational/Services/CPSO/CPD Committee
Policy Statement	To confirm that educational credits claimed were indeed attended.
Procedure	1. Starting at the beginning of the cycle October 1, 2014, members need to collect and save proof of attendance at an educational activity or proof of having carried out the activity claimed in the educational record on the web-application 2. Audits will be carried out one year at a time, on 5% of the members who are using the GPPA as their pathway. 3. Members to be audited will be chosen at random from those using the GPPA as their Third Pathway. (See the process under 3.1.A.ix.e {i}) 4. Members chosen will be asked to provide proof of those activities that are specified in the request for documents of proof. (See 3.1.A.ix.e {ii} for the method to be used to choose the items for audit) 5. The date by which the documents must be submitted will be stated in the request. 6. Documents are to be submitted to the GPPA Office either as scanned and then e-mailed: faxed: or photocopied and then mailed. 7. Those members chosen to be audited will be divided equally among the members of the CPSO/CPD Committee. Only one person will audit each member selected but if there are any questions/concerns then that member could consult other members of the committee. 8. The Table 3.1.A.ix.e {iii} on Page 3 2 gives the documentation required as proof of an activity. 9. The audit will be carried out using the Form for Completion of Audit – CPSO/CPD Committee (See 3.1.A.ix.e {iv}) 10. The letters will be sent out in mid-November to the members who will be audited with a request to return the evidence by February 28.
Responsibility / Monitoring	Chair of the CPSO/CPD Committee, Chair of the Professional Development Committee and Chair of the Membership Committee
Effective Date	October 1, 2014
Original Date	March 27 2014
Date Revised	November 26, 2015

3.1.A.ix.e {i}) Members to be audited will be chosen at random as follows:
i. Create an alphabetical list of all those using the GPPA as their pathway for reporting credits.
ii. Give a number to each member on this list
iii. Calculate 5% of these (approx. 8).
iv. Select random names by using the website www.random.org
iv. Enter the numbers and press "generate" and it will give a number.
v. Repeat this 7 times (total of 8) for 5% of the members.

3.1.A.ix.e {ii} The method to be used to select the items to be audited
i. 10 items will be chosen by each auditor.
ii. Half the items will be chosen from CE and half the items from CCI. It was decided not to audit the self-directed items.
Iii. The first two items from each month (one CE and one CCI) will be chosen to a total of 10 items.
iv. If similar items are repeated then the next item from that month will be chosen.
v. As many categories as possible will be covered but self-directed CE will not be included.

See next page(Page 3) for
3.1.A.ix.e {iii} the list of the documentation required as proof of an activity.

Then see next page (Page 4) for 3.1.A.ix.e {iv} the Form for Completion of Audit – CPSO/ CPD Committee

3.1.A.ix.e {iii} Documentation required as proof of an activity.

Educational Activity	Proof
Self-Directed CE	
Audio/video tape	Title, author only
Book/Journal	Title, author only
CD-ROM	Title, author only
Internet usage	Receipt of payment for course if applicable.
Teaching preparation	Course curriculum, keep brochure if there is one, state course objectives, location, name of course and planned date.
Writing an article	The published article or internet link to same
Group CE	
Conference	Certificate of attendance if available or receipt of payment if not.
Course	Certificate of attendance if available or receipt of payment if not.
Seminar	Certificate of attendance if available or receipt of payment if not.
Teaching	Signed statement from supervisor/organizer, that they taught the course, with dates, number of hours etc.
Workshop	Certificate of attendance if available or receipt of payment if not.
CCI	
Listserv (CCI)	1 e-mail response printed out and saved per year
Case supervision (As Supervisor)	Signed certificate of attendance, (can be signed by both parties), with date and number of hours. Or receipts of payment stating date
Case supervision (As Supervisee)	Signed certificate of attendance, (can be signed by both parties), with date and number of hours. Or receipts of payment stating date
Meeting (Committee, Board, AGM - GPPA or other)	Minutes of meeting this will give Those Present and the times of the meetings.
Discussion with fellow mental health professional	Nothing required
Discussion with fellow mental health professional at all day CE	Certificate of attendance

Form for Completion of Audit – CPSO/ CPD Committee

Name: Address:

GPPA number:

CPSO number:

CPD Audit Date Range: _____

CPD Activities audited:

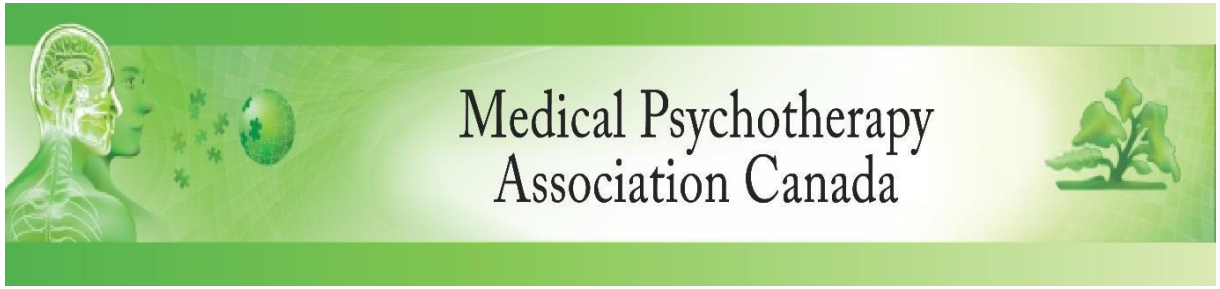
Date	Event	Confirmed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

3.1.A.ix.e {iv} the CPSO/CPD Audit Form

APPENDIX M

Insufficient CE/CCI
Clinical CPSO/CPD Members and Certificant and Mentor members
using the GPPA as the pathway for CPSO

Title	Insufficient CE/CCI – Clinical CPSO/CPD Members and Certificant and Mentor members using the GPPA as the pathway for CPSO
Number	3.1.A.vii (b)
Policy Area	Operational/Services/Membership/CPSO/CPD
Policy Statement	If a CPSO/CPD member, or a Certificant or Mentor member using the GPPA as their pathway, does not meet their specific CE/CCI requirements for the cycle, they will be notified at the end of the cycle and given instructions as to what they are required to do.
Procedure	On or around October 1st they will be sent a registered letter, to inform them of the insufficiency, and that they have until November 15th to enter their credits into the system. It will also warn them of the consequences if they don't. After November 15th the remaining members with insufficient credits will be informed of the following requirements: 1. For first year of the next cycle (e.g. October 1, 2014 to September 30, 2015) the member will be required to enter a minimum of 25 hours of any combination of CE and CCI, in addition to making up the deficient hours. The full requirement is 25 hours of CE and 25 hours of CCI per year. 2. The member will be required to outline a plan to ensure that he/she will have sufficient credits for the next complete cycle ending e.g. on September 30, 2017. The plan needs to be received by the following January 31. If a member does not comply with these requirements, it may be necessary to inform the CPSO.
Responsibility / Monitoring	CPSO/CPD Committee and Membership Committee
Effective Date	January 22, 2015
Original Date	October 23, 2014
Date Reviewed	
Date Revised	May 19, 2016



RENEWAL OF APPLICATION TO CPSO TO BE A THIRD PATHWAY FOR CONTINUING PROFESSIONAL DEVELOPMENT (CPD) 2016

Presented by

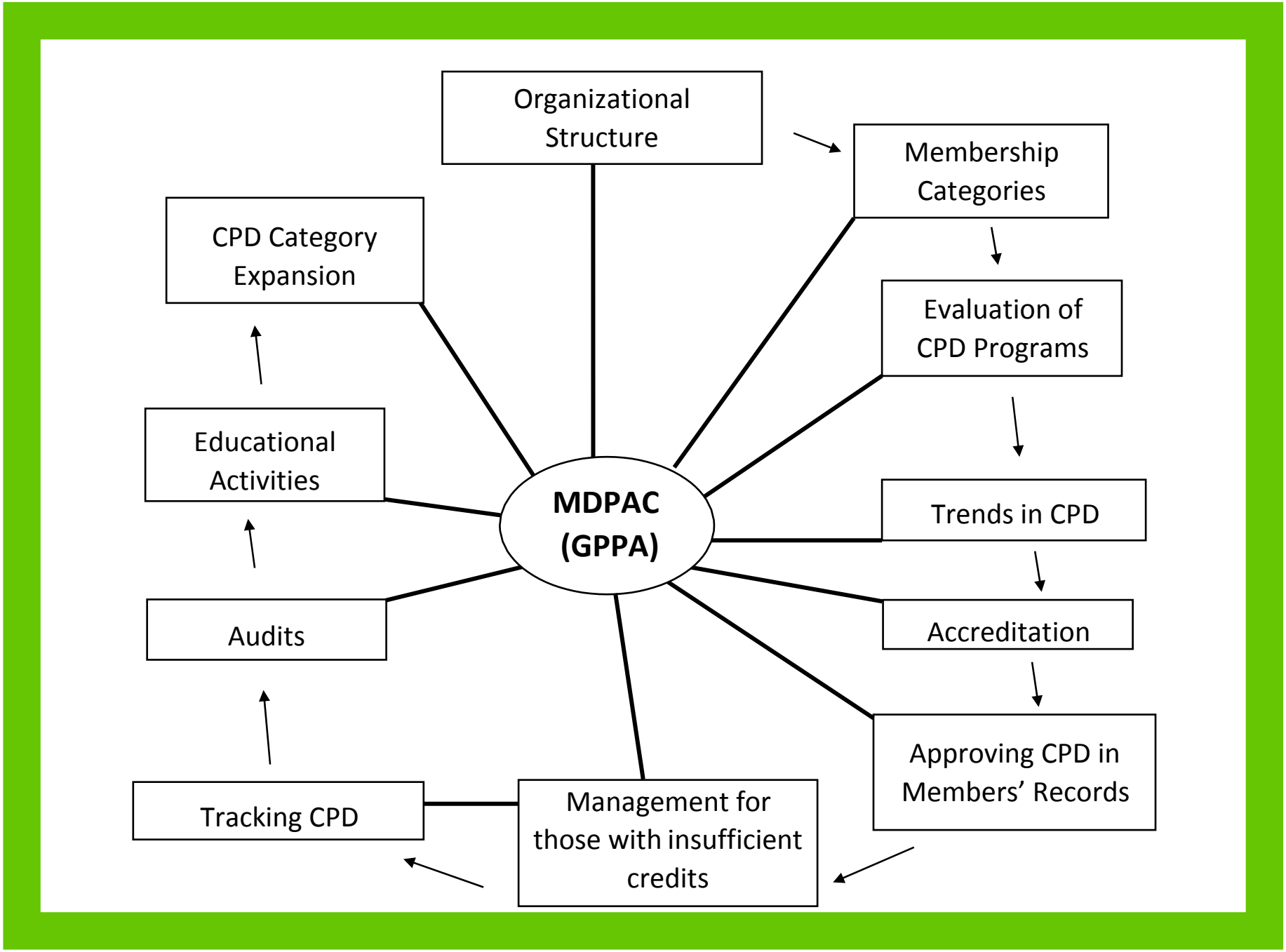
Dr. Muriel J. van Lierop, MBBS, MDPAC(M)
Chair of the CPSO/CPD & Professional Development Committees of the MDPAC/GPPA

Dr. Andrew Toplack MD

Member of Membership and CPSO/CPD Committees

Dr. Stephen Sutherland, MD

Professional Development Committee and the MDPAC/GPPA Board


Organizational Structure
Membership Categories
Evaluation of CPD Programs
Trends in CPD
Accreditation
Approving CPD in Members' Records
Management for those with insufficient credits
Tracking CPD
Audits
Educational Activities
CPD Category Expansion
MDPAC (GPPA)

ORGANIZATION STRUCTURE

- New name

Special Meeting on Sunday, December 20th, 2015 to discuss and vote on the name change. New name is ***Medical Psychotherapy Association Canada*** (MDPAC or in French ACPMD)

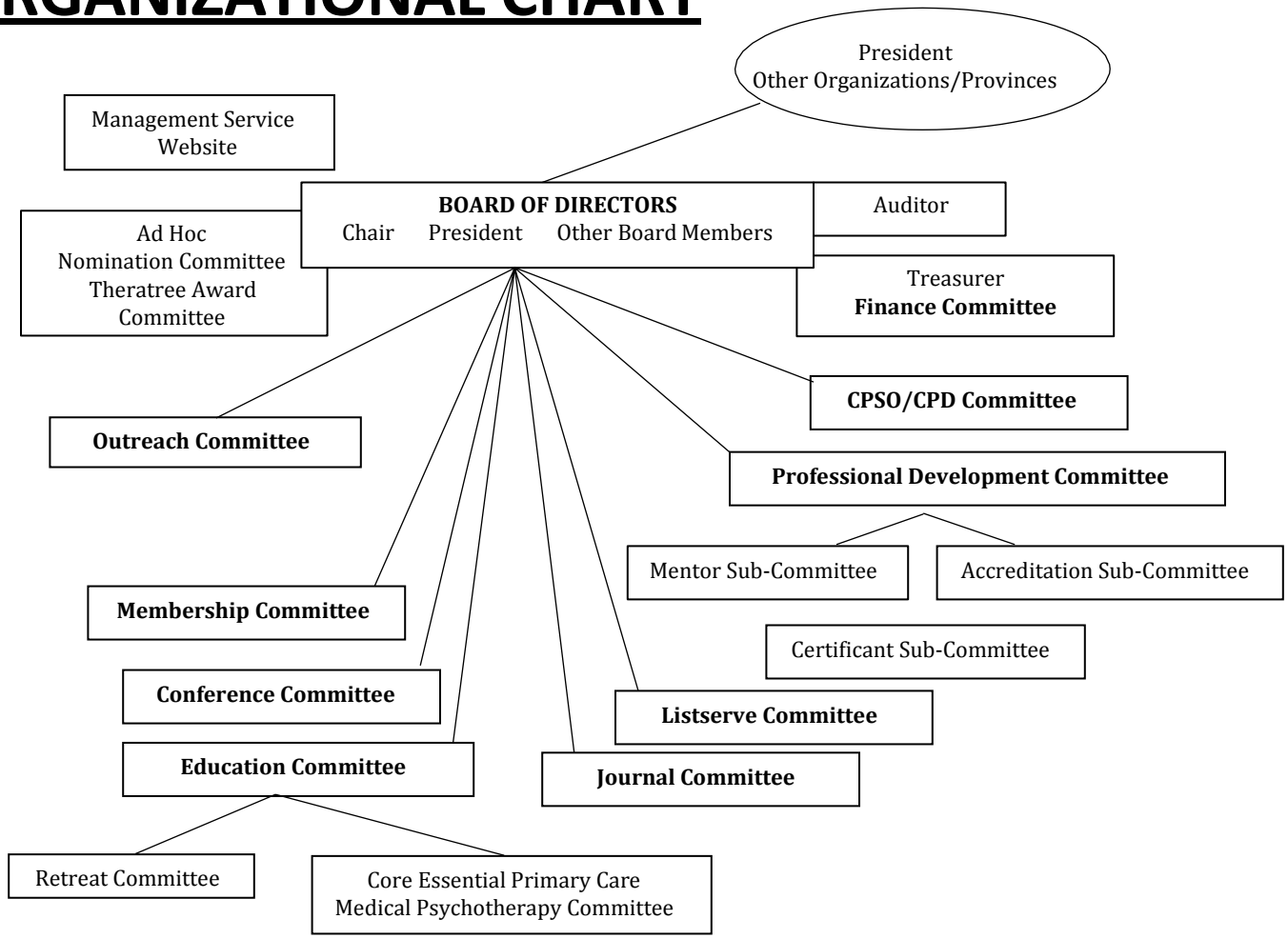
- New logo

This has been chosen and colours are being finalized.

- New Bylaws

Passed at the AGM on May 24, 2014. Year end was changed to December 31st conform - to be within 6 months of the AGM

ORGANIZATIONAL CHART



MEMBERSHIP CATEGORIES

- New Category since 2013

Clinical CPSO/CPD for recording CPD

- medical licence in Ontario
- CPSO can confirm that member has credits
- member gives consent to report CPD to CPSO
- practice is 51% psychotherapy/mental health/addictions
- required: 25 hours per year CE credits and 25 hours per year CCI credits

MEMBERSHIP CATEGORIES

Changes in 2 categories

- **Associate Member** – only physicians

  (used to have non-physicians)

  no CPD Credits required – no voting rights

- **Mentor Emeritus** – Mentor Members -
  - no longer in active practice
  - want to teach and supervise

  Required: 25 hours per year CE credits and
  25 hours per year CCI credits

  (used to have no CPD requirements)

EVALUATION OF CPD PROGRAMS

Professional Development Committee

Committee most involved – refers to the Board

Resources researched and utilized:

Royal College of Physicians and Surgeons
College of Family Physicians
Attending National Accreditation Conference
Canadian Psychological Association
College of Psychologist of Ontario
College of Registered Psychotherapists of Ontario (CRPO)

TRENDS IN CPD

The trends in CPD include the following:

- **Assessment** (either self-assessment or more formal peer-assessment) as a specific and valued educational activity
- **Needs-based learning** as being superior to passive learning
- Awareness of the potential of **Industry bias** in CPD
- Movement **away from limited maximums towards mandatory minimums**, so that members feel all their CPD credits are counted (but that preferred activities are still encouraged)

ACCREDITATION

- Application for MDPAC/GPPA Accreditation Forms

  (on Website for download)

  1. For conferences, seminars, courses
  2. For On Line Courses

- MDPAC/GPPA Internal Accreditation Forms

  1. For conferences, seminars, courses
  2. For On Line Courses

- Response letter

  Sent to applicant with details of accreditation.

- Drop box

  Managed by Assistant – storing all the details

APPROVING CPD IN MEMBERS' RECORDS

- Membership Committee members do this work
- New members trained by an experienced member
- There is a Policy about monitoring the CE/CCI
- There is also Procedure outlining how this is done
- A Reference Manual has been developed
  - clearly states what can be approved for credits

MANAGEMENT OF INSUFFICIENT CREDITS

- Assessment is at the end of the 3 year cycle
- If insufficient on Oct. 1st, a registered letter is sent
- Credits to be entered by November 15th
- If still insufficient by November 15th
  - – the deficit will be required to be made up
  - - computer programme states the deficit
  - - credits will only be credited for new cycle when deficit made up

MANAGEMENT OF INSUFFICIENT CREDITS

If still insufficient by November 15th

- This deficit is entered into the CE/CCI Recording Programme to be made up before credits added
- Also the member is asked to submit their plan to ensure sufficient credits for coming cycle
- Plan to be submitted by January 31st.

MANAGEMENT OF INSUFFICIENT CREDITS

21 members (some using MDPAC/GPPA as their pathway) had insufficient credits at end of cycle Nov 15, 2014

Follow-up of these shows the following:

- 5 said they are not using MDPAC as their pathway
- 4 have retired
- 1 has a Leave of Absence
- 1 is living in USA
- 6 have not renewed membership (reason unknown)
- 4 sent in a plan and/or have made up the deficit

TRACKING CPD

- The GPPA has a new full, operational database for tracking of CPD
- Secure log-in,
- More “user friendly” program.
- On opening the program – summary
- The requirements for the year or the cycle
- Summary of credits approved to date
- This is a reminder of the requirements.

TRACKING CPD

- Entries can be put in an “editing mode”
- When ready sent to “awaiting approval mode”
- A definition is shown immediately when an activity is chosen
- Definition is to help members enter the correct Continuing Educational (CE) or Continuing Collegial Interaction (CCI) activity.

FEATURES OF THE NEW COMPUTERIZED TRACKING CPD

- Membership Committee members can review the credits entered and
- Approve or reject CPD credits online.
- If rejected the reason is entered into the program, for the member to see.
- The date the entry was made and the date the entry was approved are recorded in the program.

CE/CCI SUMMARIES CAN BE ACCESSED

Category Assignments

Year	Category	CE Required	Maximum Self-Directed allowed	CCI Required	Maximum Listserv allowed
Oct/2014-Sept/2015	Clinical CPSO/CPD	25h	(11h 40 m)	25h	(11h 40 m)
Oct/2015-Sept/2016	Clinical CPSO/CPD	25h	(11h 40 m)	25h	(11h 40 m)
Total		50h	(23h 20m)	50h	(23h 20m)

Progress

	CE Self-Directed	CE Group	CE Total	CCI Listserv	CCI Other	CCI Total
Approved	38h 55m	49h 30m		0h	37h	
Credited	23h 20 m	49h 30m	72h 50m	0h	37h	37h
Carry Over			5h			5h
Total Credited			77h 50m			42h
Required			50h			50h
Progress			100.00%			84.00%

CE/CCI SUMMARIES CAN BE ACCESSED

Insufficient credits seen clearly in the Summary

Progress

Credited_____

Shortfall made up_____

Total Credited_____

Required_____

Outstanding Shortfall_____

Total Required_____

Progress _____

AUDITS

Audit to confirm educational activities were done

- Members told what to keep as evidence
- Audit done at end of 1st year of the cycle – Nov. '15
- Members numbered alphabetically – numbers used
- 8 selected randomly using the website random.org.

AUDITS

- Letters requesting specific evidence sent
- Information/evidence to be received by Feb. 28, ’16
- Members of CPSO/CPD Committee reviewed all the evidence submitted
- All but 1 had completed the audit satisfactorily
- These were sent an acknowledging letter
- One did not submit sufficient evidence –

  - told there would be a re-audit of 2015-2016

- This member who did not comply has resigned

EDUCATIONAL ACTIVITIES

- **Conference Committee**
  - provides an Annual Conference every year
- **Education Committee**
  - provides telephone courses several times a year
- **2 Sub-Committees of Education Committee**
  - Retreat Committee – annual retreat since 2012
  - Core Essentials in Primary Care Medical Psychotherapy Committee – planning courses

CPD CATEGORY EXPANSION

New Category - On Line Group CE

Criteria for this On Line Group CE is to have all of the following in the module(s):

- (a) didactic or required reading component;
- (b) videotaped actual or simulated session as a teaching tool for each module;
- (c) interactive component ("virtual therapist", posting of on-line comments or other interactive activity) and
- (d) a self-assessment activity (quiz or test).

CPD CATEGORY EXPANSION

These are the choices in the program

CE/Self-directed

Audio/Video tape
Book/Journal
CD-ROM
Internet
Teaching preparation
Writing an article
Peer assessment - preparation as assessee
Peer assessment - review as assessor

CE/Group

Conference
Course
Seminar
Workshop
Teaching
Online Group CE

Continuing Collegial Interaction (CCI)

Case supervision (as supervisor)
Case supervision (as supervisee)
Meeting
(Committee, Board, AGM - GPPA or other)
Discussion with colleague - e.g. case
Peer Assessment Discussion (as assessor)
Peer Assessment Discussion (as assessee)
GPPA Listserv

CPD CATEGORY EXPANSION

- On Line courses approved by the MDPAC can be claimed for a maximum of 15 hours per cycle by Clinical CPSO/CPD, Certificant and Mentor members and
- On Line courses approved by the MDPAC can be claimed for a maximum of 7.5 hours by Clinical members.
- Hours over the maximum can be claimed as Self-Directed CE
- There is no CCI for this course.

CPD CATEGORY EXPANSION WORK IN PROGRESS

Supervision

- Policies and procedures related to “supervision” are being developed. (Supervision is not related to remediation)
- Supervision is a CPD activity common to all psychotherapies

In Supervision

- a psychotherapist meets with an experienced mentor
- discusses clinical cases he/she is currently engaged in
- receives advice and mentoring

CPD CATEGORY EXPANSION
WORK IN PROGRESS

- Integrating the CanMEDS Guidelines into the overall CPD program

- Awareness of the Potential for Industry Bias in CPD

  Developing Policies and Procedures

MDPAC
ACPMD

MEDICAL PSYCHOTHERAPY
ASSOCIATION CANADA

ASSOCIATION CANADIENNE
DE PSYCHOTHÉRAPIE MÉDICALE

80 College Street, Toronto, Ontario M5G 2E2 Tel: (416) 967-2600 Toll Free: (800) 268-7096 Fax: (416) 961-3330

January 26, 2017

Dr. Muriel J. van Lierop
Chair, CPSO/CPD and Professional Development Committees
Medical Psychotherapy Association Canada (formerly, General Practice Psychotherapy Association)
312 Oakwood Court
Newmarket,
Ontario L3Y 3C8

Dear Dr. Van Lierop:

On behalf of the College of Physicians and Surgeons of Ontario (CPSO), I am writing in follow-up to your presentation to the Education Committee on September 14t\ 2016. As per your 2016 email correspondence with Jennifer Fillingham, Education Lead, we are pleased to confirm that the Education Committee has extended your status as a Third Pathway CPD Tracking Organization until September 15[1] , 2019. We would like to apologize for the delay in formally communicating this information; as you are aware we had to clarify the final decision-making process at a recent meeting of the Executive Committee.

The Education Committee's final decision was based on your annual reports and presentations to Committee in 2014, 2015 and in September 2016. The Committee continues to be impressed with the dedication with which the Medical Psychotherapy Association of Canada (MDPAC) has undertaken the work of being our only Third Pathway CPD tracking organization. We will continue to require annual written reports each fall, but we probably will not require a presentation again until 2019.

As you know with respect to the CPD regulatory requirement (Quality Assurance Regulation (O. Reg. 346/11 under the Medicine Act - Section 29, Part 1)), the focus of our efforts over the last several years has been to ensure that members are signed up and reporting to one of the three CPD tracking organizations. However, our focus will soo r\' shift to ensuring that members are fully compliant with the requirements of their respective CPD tracking organizations (e.g., meeting minimum annual credit requirements among other things). This will involve continued discussions between the CPSO and the three CPD tracking organizations to ensure alignment and implementation of audit policies, data sharing, and consequences of non-compliance. We look forward to our continued collaboration with MDPAC on this work.

80 College Street, Toronto, Ontario MSG 2E2 Tel: (416) 967-2600 Toll Free: (800) 268-7096 Fax: (416) 961-3330

Additionally, as the Canadian CPD environment evolves, the CPSO will be considering how best to consider and integrate important trends. This may include requests for specific information in your annual reports or throughout the year. One of our current areas of interest is CPD and scope of practice. While neither the RCPSC nor the CFPC have requirements that their members participate in CPD within their scope of practice, the Committee expressed interest in better understanding how many family physicians may only be tracking their CPD with MDPAC. To this point, we wonder if the MDPAC has information about how many of its members are also members of the CFPC. Our Education Lead, Jennifer, will be following up with you about this request.

Once again we appreciate all your efforts and are pleased to extend your status as a Third Pathway for the next three years. This decision will be communicated to Council at its meeting in February 2017.

Sincerely,

Barbara Lent, MD, CCFP,
FCFP Chair, Education
Committee

cc: Wade
Hillier
Director
Quality Management Division

80 College Street, Toronto, Ontario M5G 2E2 Tel: (416) 967-2600 Toll Free: (800) 268-7096 Fax: (416) 961-3330

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

TOPIC: **Policy Report**

DATE: **February 2017**

Items For Information

Updates:

1. Post-MD – Non-Residency Programs
2. Mifegymiso - Abortion Combination Pill
3. Policy Consultation Update:
    I. Accepting New Patients
    II. Ending the Physician-Patient Relationship
4. Policy Status Table

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1. Post-MD – Non-Residency Programs

- Ontario Medical Schools are currently developing programs for learners who are unsuccessful in obtaining a residency position. To date, the College has been asked for its view on three of these programs. Initially Queen's University ("Queen's") contacted the College about a program that was still in development and subsequently the University of Toronto ("UofT") and University of Ottawa ("uOttawa") jointly sought feedback on programs already on offer at their institutions.

- While there are differences between the programs, each includes clinical experience components in order to help learners maintain or enhance their clinical skills while they wait to re-apply for a residency position in the future.

- As a result, the College's analysis included determining under what authority learners would be permitted to perform controlled acts. In particular, whether a provision in the *Regulated Health Professions Act, 1991* (*RHPA*) that permits students to perform controlled acts would apply or whether delegation might be appropriate.

- Under the *RHPA* undergraduate medical students are permitted to perform controlled acts when they are acting under the supervision of a member of the profession and when they are "fulfilling the requirements to become a member of a health profession." (Section 29(1) (b) of the *RHPA*).

- The College's *Delegation of Controlled Acts* policy requires that delegation only be done when it is in the patient's best interest to do so (i.e., in order to facilitate the timely delivery of health care and promote optimal use of health care resources and personnel).

- With feedback and direction from Education Committee and Executive Committee it was determined that the Queen's proposed program did not align with the *RHPA* nor College policy, whereas, provided that certain conditions were satisfied, the UofT and uOttawa programs would be consistent with the *RHPA* provision that authorizes students to perform controlled acts.

    - As the proposed Queen's program is intended for MD graduates and is *not* a part of the process to licensure, it was determined that students of the program would not be "fulfilling the requirements to become a member of a health profession". As such, they would not be authorized by the *RHPA* to perform controlled acts. Additionally, as delegation is only intended to be used when it is in the patient's best interest to do so, not in order to facilitate the maintenance or enhancement of a student's clinical skills, delegation in this context would not align with the College's *Delegation of Controlled Acts* policy.

    - In contrast, the UofT and uOttawa programs are only available to unmatched undergraduate students of the respective institution and are structured, or are being restructured, such that students retain their status as an undergraduate medical student and graduation is deferred until after successful completion of the program. Provided that the program is structured in this way, the performance of controlled acts as part of these programs would constitute "fulfilling the requirements to become a member of a health profession" and so would be consistent with the *RHPA*.

- On the basis of the above analysis, a response was sent to Queen's outlining problems with their proposed program from both a legislative and policy perspective and a response was sent to UofT and uOttawa outlining the conditions under which the offered programs would be viewed as conforming to the legislation (i.e., if students retain their status as undergraduate students and conferral of their degree is deferred) (**Appendix A**).

- In accordance with the direction of the Education Committee and Executive Committee, the response to UofT and uOttawa also included additional

recommendations for the consideration of both institutions and a follow-up letter was sent to Queen's outlining our response to UofT and uOttawa as Queen's may be interested in restructuring their own program. Finally, as directed by the Executive Committee, Dr. Gerace also shared this analysis with all the faculties of medicine at a recent meeting of the Council of Ontario Faculties of Medicine.

2. Mifegymiso – Abortion Combination Pill

- Mifegymiso, a combination formula of mifepristone/misoprostol, has been approved for use in Canada to achieve medical abortion in early pregnancy. The medication induces a miscarriage-like process and no surgical intervention is required.

- Many commentators have noted that Health Canada's approval of Mifegymiso is a positive step in supporting autonomy in relation to women's reproductive health as it provides an alternative to surgical abortions and supports access to care.

- Currently, access to abortion services varies by geographical location; resources are concentrated in urban centres, and providing an alternative to surgical abortions increases access to those living outside of well-resourced areas while still ensuring safe care provision.

- Mifegymiso has been available in France for decades. It is also available in other jurisdictions like the US, and Australia.

- Health Canada approved Mifegymiso for use in accordance with a product monograph submitted by Celopharma Inc. The product monograph states:

    1. Mifegymiso would only be prescribed and dispensed by physicians
    2. Physicians would undergo training and be registered prior to dispensing Mifegymiso (Training is available through the Society of Obstetricians and Gynaecologists of Canada)
    3. The physician shall confirm gestational age by ultrasound and exclude ectopic pregnancy
    4. The registered physician would supervise the administration of mifepristone by the patient

- The provision in the product monograph that limits the prescribing and dispensing of the medication to physicians-only resulted in confusion over the dispensing process for Mifegymiso. It was unclear whether physicians and pharmacists in Ontario could proceed with dispensing Mifegymiso in the same way as other medications.

- The monograph requirement for physician-only dispensing has garnered significant criticism, with concerns that it will impede access. Very few

physicians dispense drugs. In Ontario, approximately 20 physicians dispense medications directly to patients.

- In response to concerns about access, the College of Physicians and Surgeons of BC together with the BC College of Pharmacists wrote a joint letter to Health Canada expressing concerns about the requirement for physician-only dispensing of Mifegymiso. In BC, like Ontario, very few physicians dispense.

- In reply, Health Canada stated that the product monograph wasn't binding, and that pharmacist-dispensing of Mifegymiso would be considered 'off-label' and therefore would be acceptable to Health Canada.

- In accordance with the Executive Committee direction at a special meeting on November 25th, 2016, a joint letter from the College and the Ontario College of Pharmacists (OCP) was developed seeking clarification that Ontario physicians and pharmacists could also rely on the assurances Health Canada provided to BC. The Executive Committee also sought clarification that Mifegymiso could be provided directly to the patient, and that there was not a requirement for the physician to observe the patient consuming the medication.

- This letter was finalized with feedback from Dr. Rouselle, Dr. Gerace and the Ontario College of Pharmacists. It was sent to Health Canada on December 15, 2016. A copy of the letter is attached as **Appendix B**.

- On January 11, 2017 both Colleges received a response from Health Canada providing clarification on the processes of dispensing and administering that Health Canada would consider to be aligned with the current product monograph. A copy of the letter is attached as **Appendix C**.

- At the meeting of the Executive Committee in January, the Committee heard a presentation by Dr. Sheila Dunn, a physician with extensive experience in this area. Dr. Dunn provided background information along with an overview of a training module that was developed by the Society of Obstetricians and Gynecologists of Canada and other partners.

- The Executive Committee directed staff to draft messaging to the membership explaining the prescribing and dispensing processes for Mifegymiso, and to work with OCP on the messaging that will go to their membership. That work is currently underway.

3. Policy Consultation Update

I. Accepting New Patients

- The College's Accepting New Patients policy is currently under review. The policy sets out physicians' professional and legal obligations when accepting new

patients, and emphasizes that physicians must accept new patients in a fair and professional manner. This is achieved, in part, by accepting new patients on a first-come, first-served basis.

- A Working Group was struck to lead the policy review process. The new draft policy is informed by research undertaken, feedback received through the preliminary consultation period, and the results of public polling.

- The draft policy was approved for external consultation by Council at the December 2016 meeting. The consultation commenced following the meeting.

- As of February 3, 2017, the Council submission deadline, the College has received a total of 94 responses. These include 47 comments on the College's online discussion page (45 comments from physicians and 2 from the public), and 47 online surveys (36 submitted by physicians, 6 by members of the public, 3 by other health care professionals, and 2 from organizations[1]).

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines.

- Stakeholders provided feedback covering a range of issues pertaining to accepting new patients. A few of the key themes that have emerged throughout the consultation are described below.

  i. **Support for draft policy**

  - **Support for first come, first-served:** Many physician respondents expressed support for the first come first served approach and the expectation that physicians refrain from "cherry picking" patients.

  - **Clarity, Comprehensiveness, Reasonableness:** A majority of survey respondents felt the draft policy is clear, comprehensive, and reasonable.

  ii. **Suggestions for improvement**

  - **Physician Autonomy:** Some physicians expressed that physicians should be able to determine who they accept into their practices and should not have to use a first-come, first-served approach. Some physician respondents also expressed that they should be able to balance their own practices, or refuse patients who are rude, abusive and/or are "doctor shopping".

  - **Prioritizing patients without family physicians:** Some respondents commented that patients without family doctors should be prioritized and that the draft should be updated to reflect this. Some members of the public

[1] The College of Physicians and Surgeons of Alberta and the North Simcoe Muskoka CCAC completed the survey.

shared the difficulty they have had switching to a new family physician without first ending the relationship with their current family doctor, and the impact this has had on their health.

- **Meet and Greet Appointments:** Some respondents commented that further clarification is required around the use of meet and greet appointments. Specifically, that the policy should clarify that meet and greet appointments may be an essential step in establishing the physician-patient relationship.

iii. **Requests for clarification**

- **Application of policy to specialists:** Some respondents requested clarification about how the first-come, first-served approach applies to physicians providing specialty care. Some respondents indicated that the policy does not take into account or address how referrals are triaged.

- **Prioritizing those in need:** Some respondents indicated that the policy should more clearly articulate the circumstances where prioritizing patients based on need would be appropriate.

Next Steps

- All feedback received will be carefully reviewed and used to evaluate and revise the draft policy. The revised draft policy will be presented to the Executive Committee and Council for its consideration for final approval later this year.

II. Ending the Physician-Patient Relationship

- The College's Ending the Physician-Patient Relationship policy is currently under review by a Working Group consisting of public and physician members of Council.

- A Working Group was struck to lead the policy review process. The new draft policy is informed by research undertaken, feedback received through the preliminary consultation period, and the results of public polling.

- The draft policy was approved for external consultation by Council at the December, 2016 meeting. The consultation commenced following the meeting.

- Overall, the draft policy retains the key content and central principles of the current policy, while changes have been made to enhance clarity and flow, to address issues not currently addressed by the current policy, and to ensure alignment and consistency with other College policies.

- As of February 3, 2017, the College has received a total of 82 responses. These include 41 comments on the College's online discussion page (35 comments

from physicians, 4 from the public, 1 from someone who preferred not to say, and 1 from an organization[2]), and 41 online surveys (36 submitted by physicians, 3 by members of the public, 1 by another health care professional, and 1 who preferred not to say).

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines.

- Stakeholders provided feedback covering a range of issues pertaining to the draft policy. A few of the key themes that have emerged throughout the consultation are described below.

i. Clarity

- **Overall**: Survey respondents generally felt that the draft policy is clear, easy to understand, well organized and clearly written. Some respondents suggested the policy include more examples of appropriate and inappropriate reasons for ending a treating relationship.

- **Application of policy to specialists:** Survey respondents were divided about whether they feel it is clear how the draft policy applies to specialist physicians. Some respondents requested clarification on how the policy applies where a referral has been made, and questioned whether it is sufficient for specialists to notify family physicians of the discontinuation of the treating relationship.

ii. Suggestions for Improvement

- **Physicians' "right" to terminate patients:** A few physician respondents expressed the view that the draft policy does not adequately support what they feel is their right to end the physician-patient relationship where they see fit, or in response to threatening or abusive behaviour.

- **Fear of complaints:** Some physicians expressed that the policy makes it too difficult to end a relationship with a patient, and does not adequately protect physicians from frivolous complaints.

- **Rostered practices**: Many physician respondents expressed that they should be able to terminate a patient who seeks treatment outside of their rostered practice.

- **Failure to pay fees and missed appointments:** Many physician respondents expressed that the policy should allow physicians to discontinue a treating relationship where the patient has failed to pay an outstanding fee or frequently misses appointments.

[2] The organizational respondent was the Information and Privacy Commissioner of Ontario (IPC).

Next Steps

- All feedback received will be carefully reviewed and used to evaluate and revise the draft policy. The revised draft policy will be presented to the Executive Committee and Council for its consideration for final approval later this year.

4. 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 D**. This table will be updated at each Council meeting.

- For further information about the status of any policy issue, please contact Andréa Foti, Manager, Policy, at extension 387.

DECISIONS FOR COUNCIL: For information only.

CONTACTS: Andréa Foti, ext. 387

DATE: February 3, 2017

Appendices:

Appendix A: Response Letter to University of Toronto and University of Ottawa

Appendix B: Mifegymiso - Letter to Health Canada

Appendix C: Health Canada Response

Appendix D: Policy Status Table

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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January 26, 2017

Dr. Patricia Houston
Vice Dean, MD Program
Faculty of Medicine
University of Toronto
Medical Sciences Building
1 King's College Circle
Toronto, ON M5S 1A8

Dr. Melissa Forgie
Vice Dean, UME
Faculty of Medicine
University of Ottawa
Roger Guindon Hall
451 Smyth Road
Ottawa, ON K1H 8M5

Dear Dr. Houston and Dr. Forgie,

At your request, we have reviewed the information you have provided in relation to the University of Ottawa's Post-MD Enrichment Year and the University of Toronto's Post-MD Non-degree Program to assess the appropriateness of these students participating in clinical activities and to clarify what would be considered appropriate roles and supervision for these students. This matter was considered by and the response below was affirmed by both the College's Education Committee and Executive Committee.

As we understand it, the intention of these programs is to allow undergraduate students who have failed to match to a postgraduate training program to seek additional learning opportunities and to maintain and/or enhance their clinical skills while they wait to re-apply for a residency position in the subsequent year. Importantly, these students are not yet physicians, but are rather physicians in training who would participate in clinical activities along with their peers as medical students.

Each program involves students performing clinical activities, which can include 'controlled acts' as they are defined in the *Regulated Health Professions Act, 1991 (RHPA).* For this reason, our analysis involved assessing whether students of your programs would be authorized to perform controlled acts and if so by what mechanism.

The *RHPA* prohibits individuals from performing controlled acts unless they are a member of a regulated health profession that has been authorized by a health profession Act to so do (Section 27(1) (a) of the *RHPA*). There is, however, an exception to this prohibition that permits students to perform controlled acts when acting under the supervision of a member of the

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

profession and when they are "fulfilling the requirements to become a member of a health profession" (Section 29(1) (b) of the *RHPA*).

Provided that students retain their status as an undergraduate medical student and graduation is deferred until after successful completion of the program, in our view, the performance of controlled acts by students of these programs would be consistent with the *RHPA*. In particular, as successful completion of the program would be required in order to graduate, the performance of controlled acts as part of these programs would constitute "fulfilling the requirements to become a member of a health profession". We trust, however, that you are also receiving your own legal advice on this matter. We note as well that physician supervisors participating in the program would then continue to be subject to the expectations set out in the College's *Professional Responsibilities in Undergraduate Medical Education* policy.

We understand that students would not be permitted to repeat the program following a failure to match in the subsequent year and the College recommends retaining this structure moving forward. The program should not become a repository for repeatedly unmatched students. We further recommend that you track the reasons for the students' initial failed match, post-program match rates, and any factors that contributed to a subsequent match (e.g., change in specialty or location) or failure to match. This may, for example, provide important information to better understand student career selection needs (both individually and collectively) and assist students in successfully matching going forward.

Please do not hesitate to contact us if you have any further questions or concerns.

Yours truly,

Rocco Gerace, MD
Registrar

Ontario College of Pharmacists
Putting patients first since 1871

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

VIA EMAIL

December 15, 2016

Dr. Supriya Sharma
Chief Medical Advisor
Health Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9

Dear Dr. Sharma,

Re: Mifegymiso

The College of Physicians and Surgeons of Ontario (CPSO) and the Ontario College of Pharmacists (OCP) write in relation to Mifegymiso. We understand that the drug will become available to the Canadian public in January 2017 and wish to clarify details regarding requirements contained in the product monograph which may impact patient access to this drug.

We are aware that the product monograph submitted by Celopharma Inc. and approved by Health Canada states:

1. Mifegymiso will be prescribed and dispensed by physicians;
2. Physicians will undergo training and be registered prior to dispensing Mifegymiso;
3. The physician shall confirm gestational age by ultrasound and exclude ectopic pregnancy; and,
4. The registered physician will supervise the administration of mifepristone by the patient.

We understand that the College of Physicians and Surgeons of British Columbia and the College of Pharmacists of British Columbia have received confirmation from Health Canada that despite the product monograph, it is permissible for Mifegymiso to be dispensed by a pharmacist to the patient and delivered to the prescribing physician or dispensed directly to the patient with a prescription. Similar to our counterparts in British Columbia, we wish to confirm that Ontario physicians and pharmacists who have completed training regarding the safe use of Mifegymiso can proceed in this manner, and that this will be considered acceptable by Health Canada .

We also wish to confirm that consistent with Health Canada's 'Myths and Facts' document published online, that the product monograph requirement for 'supervision of the administration of mifepristone' does not require patients to consume the medication in front of the physician,

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but rather determining how and where the medication is to be ingested would be a treatment decision between the physician and the patient.

As professional regulatory authorities, the CPSO and the OCP have mandates to act first and foremost in the public interest. Ensuring Ontarians have access to approved medical treatments supports this mandate. Upon receiving a response from Health Canada providing confirmation on the two elements raised above, we intend to communicate with our respective members informing them of the need to complete training regarding Mifegymiso, as well as the options for dispensing this medication.

We appreciate Health Canada's assistance in clarifying these matters. As there may be others across the country who will seek similar clarification, Health Canada may wish to consider updating the current product monograph to provide more clarity around this medication's dispensing and administering procedures.

Yours very truly,

Rocco Gerace MD
Registrar
College of Physicians and Surgeons of Ontario

Anne Resnick, R.Ph., B.Sc.Phm., CAE
Interim Acting Registrar
Ontario College of Pharmacists

Health Canada / Santé Canada
Health Products and Food Branch / Direction générale des produits de santé et des aliments

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Ottawa, Ontario
K1A 0K9

JAN 1 1 2017

16-114838-597

Dear Dr. Gerace and Ms. Resnick,

Thank you for your letter of December 15, 2016 seeking clarity on Health Canada's position regarding the conditions of use for Mifegymiso. I've also taken the liberty to cc Nancy Lum-Wilson on this response. Nancy, congratulations on the new appointment, and I look forward to working with you again.

With respect to the issues raised in your letter, we understand from the company that Mifegymiso is expected to be available on the Canadian Market by the end of January 2017. The company has also indicated that the English educational program is currently available (https://sogc.org/online-courses/courses.html), with the French version to be available shortly.

The product monograph (PM), including Mifegymiso's conditions of use, are based on the data package provided by the sponsor to Health Canada. Please note that after the original approved product monograph was made available, professional organisations raised the issue that there was a potential for confusion as the wording regarding administration in Parts I and III was not fully consistent. To address this, the product monograph was revised in October 2016.

Specifically, Part I of the PM was revised to read: *"Mifepristone should be administered under the supervision of the prescriber. In the clinical trials supporting Mifegymiso efficacy and safety, mifepristone was administered under the supervision of a physician in a clinical setting"*. To better align with Part I, Part III was also revised and now states: "*As directed by your doctor or as given to you by medical staff"*.

The wording in the product monograph was deliberately chosen such that physicians could use their discretion for each individual patient. It does not mandate that the medication be taken in front of the physician. Such decisions are best made by the physician ands are considered the practice of medicine.

.../2

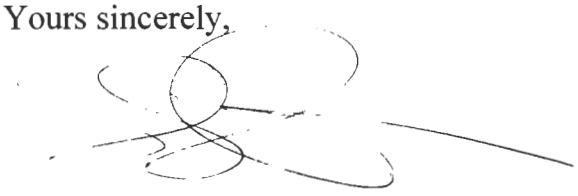
Pharmacists will be involved in the dispensing of Mifegymiso, however their role may be different than the traditional one of dispensing directly to the patient. For example, doctors may write a prescription, which is filled by a pharmacist, whereby the drug is then returned to the doctor who provides it to the patient.

The wording in the product monograph is based on the data provided to support the authorization of Mifegymiso. The product monograph is not a legally binding document. If, under the practice of medicine or pharmacy, the administration or distribution of the drug is outside of what is in the approved product monograph, the health care professional would assume any liability associated with the product being used off-label.

Revisions to the indication or conditions of use of the product will be considered if the company submits evidence supporting these changes. As with all submissions, Health Canada would apply the same rigorous scientific review to the new information.

I appreciate your organisations taking the time to write to us seeking clarity regarding the conditions of use for Mifegymiso and I hope that the above information is helpful. If you have any other questions or concerns, please don't hesitate to contact me directly.

Yours sincerely,



Dr. Supriya Sharma
Chief Medical Advisor to the Deputy Minister

cc: Nancy Lum-Wilson, Registrar Ontario College of Pharmacists

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Re-entering Practice	The current policy sets out expectations for physicians who wish to re-enter practice after a prolonged absence from practice and sets out requirements of physicians in demonstrating their competency in the area of practice they are returning to.	This policy is currently under review. A preliminary consultation was undertaken between June and August, 2016. A new draft policy is currently being prepared. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Changing Scope of Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice and sets out requirements of physicians in demonstrating their competence in the new area of practice.	This policy is currently under review. A preliminary consultation was undertaken from April 4 to June 2, 2016. This consultation will also inform work happening at the national level regarding physician scope of practice. A new draft policy is currently being prepared. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Block Fees and Uninsured Services	The current policy sets out the College's expectations of physicians who charge patients for services not paid for by the Ontario Health Insurance Plan	This policy is currently under review. A newly titled Uninsured Services: Billing and Block Fees draft policy is presented for Council's consideration to release for external consultation. Further information can be found	2017

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	(OHIP).	in the Briefing Note contained in Council's February, 2017 meeting materials.	
Accepting New Patients	The current policy provides guidance for physicians on accepting new patients for primary care.	This policy is currently under review. A Joint Working group has been struck to undertake this review along with the review of the *Ending the Physician-Patient Relationship* policy. The Working Group has developed an updated draft of the policy which was circulated for external consultation between December, 2016, and February, 2017. The draft policy will be reviewed in light of the feedback received, and a final draft of the policy will be presented to Council for consideration for final approval later this year.	2017
Ending the Physician Patient Relationship	The current policy provides guidance to physicians about how to end physician-patient relationships.	This policy is currently under review. A Joint Working Group has been struck to undertake this review along with the review of the *Accepting New Patients* policy. The Working Group has developed an updated draft of the policy which was circulated for external consultation between December, 2016, and February, 2017. The draft policy will be reviewed in light of the feedback received, and a final draft of the policy will be presented to	2017

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		Council for consideration for final approval later this year.	
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy provides guidance to physicians and to help physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991 (RHPA)* regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	This policy review will be informed by the College's Sexual Abuse Initiative and the Minister of Health and Long-Term Care's Task Force on the Prevention of Sexual Abuse of Patients. The specific timing of the review is dependent on the Ministry's work in the context of the Task Force.	tbd
Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	This policy explains the practice management measures physicians should take when they cease to practise or will not be practising for an extended period of time.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken between June and August, 2016. Further updates with respect to the status of this review will be provided at a future meeting.	2017

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Physicians and Health Emergencies	The purpose of this policy is to reaffirm the profession's commitment to the public in times of health emergencies.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken between September and November 2016. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	This policy is currently under review. A joint Working Group has been struck to undertake this review alongside the development of a new *Continuity of Care* policy. A preliminary consultation was undertaken between June and August, 2016. The working group will consider the feedback received and the research findings as it works to revise this policy.	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of the *Test Results Management* policy. A preliminary consultation was undertaken	2018

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		between June and August, 2016. The working group will consider the feedback received and the research findings as it works to develop a new draft policy.	

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015/16	This policy provides guidance to physicians on disclosing harm to patients.
Fetal Ultrasound for Non-Medical Reasons	2015/16	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds.
Anabolic Steroids	2016/17	This policy sets out the expectation that physicians should not prescribe anabolic steroids or other substances and methods for the purpose of performance enhancement in sport.
Female Genital Cutting (Mutilation)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation.
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine.
Dispensing Drugs	2016/17	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016/17	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Confidentiality of Personal Health	2016/17	This policy sets out physicians' legal and ethical obligations to protect the privacy

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Information		and confidentiality of patients' personal health information. The review of this policy is currently on hold pending the introduction of new legislation by the Ministry.
Third Party Reports	2017/18	This policy clarifies the College's expectations regarding physicians' roles in and standards of care for conducting medical examinations and/or preparing reports for third parties.
Delegation of Controlled Acts	2017/18	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Medical Records	2017/18	This policy sets out the essentials of maintaining medical records.
Mandatory and Permissive Reporting	2017/18	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.
Prescribing Drugs	2017/18	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.
Social Media – Appropriate Use by	2018/19	This document provides guidance to physicians about how to engage in social

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Physicians (Statement)		media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest: Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.

POLICY STATUS REPORT – FEBRUARY 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
for the End of Life)		
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family Members	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

TOPIC: **Medical Assistance in Dying: Update**

DATE: **February, 2017**

FOR INFORMATION

ISSUE:

- In this brief, Council is provided with an update on new and ongoing CPSO and stakeholder activities with respect to Medical Assistance in Dying.

- It will focus particularly on the provincial government's recently introduced legislation entitled the *Medical Assistance in Dying Statute Law Amendment Act, 2016* (Bill 84).

- This note is for information only.

BACKGROUND:

- The legal framework for medical assistance in dying (MAID) in Canada is the federal legislation, previously known as Bill C-14. The Bill received royal assent on June 17th 2016. It amends the *Criminal Code of Canada*.

- Both in the lead up to the federal legislation being introduced, and following its passage, a number of stakeholders have been active in providing guidance on MAID. Particularly, the CPSO together with the CNO and OCP have been active in preparing guidance, policies and other resources for their respective memberships, first tracking the requirements in the *Carter v. Canada* decision and then later, the provisions of the federal legislation.

- Details of the policies and resources developed by the CPSO, CNO and OCP have been itemized for Council in previous briefing notes to date, and therefore won't be repeated here.

- Throughout all of the work on MAID, there has been very positive collaboration, coordination, and cooperation between the CPSO, CNO, OCP, and the Ontario government, along with additional interested stakeholders such as the Ontario Hospital Association, and the Ontario College of Family Physicians.

- The Ministry of Health and Long-Term Care (MOHLTC) has, itself, engaged in a constellation of MAID-related activities. This has included:

    - The implementation of a Clinician Referral Service to help Ontario clinicians to arrange referrals for patients requesting MAID;

    - The development of clinician aids to support the provision of MAID. These include forms to assist patients who request medical assistance in dying and physicians who either provide MAID or assess a patient's eligibility for MAID; and

    - The implementation of a system that enables full coverage of MAID drugs for all eligible patients, whether in-hospital or in the community.

- In addition to these non-legislative measures, on December 7th, 2016, the Ontario government introduced the *Medical Assistance in Dying Statute Law Amendment Act, 2016* (Bill 84). The government's news release regarding Bill 84 is available online.

CURRENT STATUS:

- In this section of the brief, Council is provided with an overview of Bill 84, along with a sense of the CPSO's ongoing activity in relation to MAID.

a) Government of Ontario: Introduction of MAID Legislation (Bill 84)

- Bill 84, the *Medical Assistance in Dying Statute Law Amendment Act*, *2016*, passed First Reading on December 7, 2016. A copy of the Bill is attached as **Appendix A**.

- The Bill aligns with the federal MAID legislation. It provides greater clarity and protections on a range of issues related to MAID that fall under provincial jurisdiction.

- If passed, the Bill would amend six existing statutes. An overview of the proposed amendments to each statute is set out directly below.

The Coroners Act

- The proposed amendments would clarify the Coroner's role in relation to MAID cases.

- The proposed amendments would require that the Coroner be given notice of all MAID deaths. However, it would be left to the Coroner's discretion as to whether to hold an investigation into the death.

The Excellent Care for All Act

- The proposed amendments would provide immunity to physicians, nurse practitioners, and anyone assisting them, from actions or proceedings arising from the lawful provision of MAID. This immunity provision would not apply in cases of alleged negligence, and it does not extend to institutions where MAID is provided.

- Further, proposed amendments to the *Act* would clarify that MAID cannot be invoked as a reason to deny a right or refuse a benefit (e.g. insurance payout) that would otherwise be provided to the individual who received MAID under a contract or statute.

Freedom of Information and Protection of Privacy Act (FIPPA) & Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)

- Amendments to *FIPPA* and *MFIPPA* would ensure that identifying information about clinicians and facilities that provide MAID cannot be disclosed pursuant to a Freedom of Information (FOI) request.

- The MOHLTC has indicated that this amendment is being proposed to address safety concerns arising from the controversial nature of MAID.

- Notwithstanding these amendments, the MOHLTC strongly encourages health care facilities to develop MAID policies and procedures and to share those with the public so that patients can make informed choices about their care options.

Vital Statistics Act

- Proposed amendments to the *Vital Statistics Act* complement those proposed to be made to the *Coroners Act.*

- The proposed amendments clarify that the Coroner does not need to complete the medical certificate of death for all MAID deaths. The Coroner would only complete the medical certificate of death where an investigation is undertaken. Where no investigation is undertaken, the physician or nurse practitioner involved would complete the death certificate.

- The Ministry of Government and Consumer Services, in consultation with the Coroner, will be providing instructions to clinicians about how MAID deaths are to be registered.

- Preliminary information from the MOHLTC suggests that the patient's underlying condition would be listed on the death certificate as the cause of death. There would be no indication on the medical certificate of death that the death was due

to anything other than natural causes. For instance, the death would not be classified as 'unnatural' or as a suicide.

The Workplace Safety and Insurance Act

- The proposed amendments would clarify that for the purposes of the *Workplace Safety and Insurance Act,* a worker who received MAID would be considered to have died as a result of his or her underlying injury or disease.

- This ensures that where a worker received MAID, a claim made under the *Act* would be determined based on the illness or disease for which the worker was deemed eligible to receive MAID. The proposed amendments would ensure that workers' entitlement to benefits is not impacted by the fact that they have pursued MAID.

b) CPSO Activity

- The CPSO continues to be actively engaged in MAID, and liaise regularly with relevant stakeholders including the MOHLTC and others.

- All calls and queries from physicians and the public related to MAID continue to be managed by Public and Physician Advisory Services (PPAS). A summary of these inquiries are provided below.

- Since April 1st 2016, the CPSO has received over 200 MAID-related calls through PPAS. 53% of those calls were made by physicians; the remaining 47% were calls from members of the public.

- Broadly speaking, the majority of public calls were from individuals seeking information about how to initiate a request for medical assistance in dying; and information on finding a willing MAID provider.

- The majority of physician queries have been with respect to the CPSO's effective referral requirement; accessing drug protocols; questions regarding the Ministry of Health and Long Term Care's referral line; and inquiries related to MAID education and the requisite scope of practice for providers.

NEXT STEPS:

- The CPSO will continue to monitor all the aspects of MAID closely and will keep Council apprised of developments.

- Bill 84 is not likely to progress through the legislature until spring 2017; the legislature rose in December and will not sit again until late February.

NEXT STEPS CONT'D:

- Once Bill 84 is finalized, the CPSO will examine all MAID-related resources, including our policy and supporting documents, and make any amendments required to ensure alignment and consistency.

DECISION FOR COUNCIL:

- This item is for information only.

CONTACT: Policy Department

DATE: February 2017

Attachments:
Appendix A: Bill 84: *An Act to amend various Acts with respect to medical assistance in dying*

Appendix A

2ND SESSION, 41ST LEGISLATURE, ONTARIO
65 ELIZABETH II, 2016

Bill 84

An Act to amend various Acts with respect to medical assistance in dying

The Hon. E. Hoskins
Minister of Health and Long-Term Care

Government Bill

1st Reading	December 7, 2016
2nd Reading	
3rd Reading	
Royal Assent	

Printed by the Legislative Assembly
of Ontario

2e SESSION, 41e LÉGISLATURE, ONTARIO
65 ELIZABETH II, 2016

Projet de loi 84

Loi modifiant diverses lois en ce qui concerne l'aide médicale à mourir

L'honorable E. Hoskins
Ministre de la Santé et des Soins de longue durée

Projet de loi du gouvernement

1re lecture	7 décembre 2016
2e lecture	
3e lecture	
Sanction royale	

Imprimé par l'Assemblée législative
de l'Ontario

EXPLANATORY NOTE

Various Acts are amended in response to the Federal *Criminal Code* legislation dealing with medical assistance in dying.

The *Coroners Act* is amended to provide that, in the case of a medically assisted death, the doctor or nurse practitioner who provided the medical assistance in dying shall notify the coroner and provide the coroner with any information necessary to determine whether to investigate the death, and other people with knowledge of the death shall provide the coroner with information on request.

The *Excellent Care for All Act, 2010* is amended to provide protection against litigation for doctors, nurse practitioners and people assisting them for performing medical assistance in dying. (This does not apply where negligence is alleged.)

Also, the fact that a person received medical assistance in dying may not be invoked as a reason to deny a right or refuse a benefit or any other sum which would otherwise be provided under a contract or statute.

The *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act* are amended to provide that they do not apply to identifying information relating to medical assistance in dying.

The *Vital Statistics Act* is amended to provide that the requirements respecting the coroner's documentation do not apply in cases of medical assistance in dying if the coroner has determined that the death not be investigated.

The *Workplace Safety and Insurance Act, 1997* is amended to provide that a worker who receives medical assistance in dying is deemed to have died as a result of the injury or disease for which the worker was determined to be eligible to receive medical assistance in dying.

NOTE EXPLICATIVE

Diverses lois sont modifiées à la suite des modifications que le gouvernement fédéral a apportées au *Code criminel* relativement à l'aide médicale à mourir.

La *Loi sur les coroners* est modifiée pour prévoir qu'en cas de décès par suite de la réception de l'aide médicale à mourir, d'une part, le médecin ou l'infirmière praticienne ou l'infirmier praticien qui a fourni cette aide en avise le coroner et lui communique tout renseignement nécessaire pour établir s'il y a lieu ou non de faire une investigation et, d'autre part, quiconque a connaissance du décès communique au coroner, à sa demande, ces mêmes renseignements.

La *Loi de 2010 sur l'excellence des soins pour tous* est modifiée pour protéger les médecins, les infirmières praticiennes et infirmiers praticiens, ainsi que les personnes qui les aident dans le cadre de la prestation de l'aide médicale à mourir, contre toute poursuite (sauf en cas d'allégation de négligence).

De même, le fait qu'une personne a reçu l'aide médicale à mourir ne peut être invoqué pour refuser d'accorder un droit, un avantage ou toute autre somme qui seraient autrement prévus aux termes d'un contrat ou en vertu d'une loi.

La *Loi sur l'accès à l'information et la protection de la vie privée* et la *Loi sur l'accès à l'information municipale et la protection de la vie privée* sont modifiées pour prévoir qu'elles ne s'appliquent pas aux renseignements identificatoires se rapportant à l'aide médicale à mourir.

La *Loi sur les statistiques de l'état civil* est modifiée pour prévoir que les exigences relatives à la documentation du coroner ne s'appliquent pas aux cas d'aide médicale à mourir s'il a conclu que le décès ne devrait pas faire l'objet d'une investigation.

La *Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail* est modifiée pour prévoir qu'un travailleur qui reçoit l'aide médicale à mourir est réputé être décédé par suite de la blessure ou de la maladie pour laquelle il a été reconnu admissible à recevoir l'aide médicale à mourir.

Bill 84 **2016**

An Act to amend various Acts with respect to medical assistance in dying

Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

CORONERS ACT

1. The *Coroners Act* is amended by adding the following section:

Medical assistance in dying

10.1 (1) Where a person dies as a result of medical assistance in dying, the physician or nurse practitioner who provided the medical assistance in dying shall give notice of the death to a coroner and, if the coroner is of the opinion that the death ought to be investigated, the coroner shall investigate the circumstances of the death and if, as a result of the investigation, the coroner is of the opinion that an inquest ought to be held, the coroner shall hold an inquest upon the body.

Requirements re giving of notice

(2) The physician or nurse practitioner who provided the medical assistance in dying shall provide the coroner with any information about the facts and circumstances relating to the death that the coroner considers necessary to form an opinion about whether the death ought to be investigated, and any other person who has knowledge of the death shall provide such information on the request of the coroner.

Non-application of clause 10 (1) (f)

(3) Clause 10 (1) (f) does not apply in respect of a deceased person who died as a result of medical assistance in dying.

Review

(4) The Minister shall, within two years after the *Medical Assistance in Dying Statute Law Amendment Act, 2016* receives Royal Assent, establish a process to review the provisions of this section.

Definitions

(5) In this section,

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada); ("aide médicale à mourir")

"nurse practitioner" means a registered nurse who holds

Projet de loi 84 **2016**

Loi modifiant diverses lois en ce qui concerne l'aide médicale à mourir

Sa Majesté, sur l'avis et avec le consentement de l'Assemblée législative de la province de l'Ontario, édicte :

LOI SUR LES CORONERS

1. La *Loi sur les coroners* est modifiée par adjonction de l'article suivant :

Aide médicale à mourir

10.1 (1) En cas de décès d'une personne par suite de la réception de l'aide médicale à mourir, le médecin ou l'infirmière praticienne ou l'infirmier praticien qui a fourni l'aide médicale à mourir donne avis du décès à un coroner. Si le coroner est d'avis que le décès devrait faire l'objet d'une investigation, il fait une investigation sur les circonstances du décès et si, par suite de cette investigation, il est d'avis qu'une enquête devrait être tenue, il tient cette enquête.

Exigences relatives à la remise de l'avis

(2) Le médecin ou l'infirmière praticienne ou l'infirmier praticien qui a fourni l'aide médicale à mourir communique au coroner des renseignements sur les faits et les circonstances entourant le décès que le coroner juge nécessaires pour se faire une opinion sur la question de savoir si le décès devrait faire ou non l'objet d'une investigation. De plus, quiconque a connaissance du décès communique au coroner, à sa demande, ces mêmes renseignements.

Non-application de l'alinéa 10 (1) f)

(3) L'alinéa 10 (1) f) ne s'applique pas relativement à une personne décédée par suite de la réception de l'aide médicale à mourir.

Examen

(4) Dans les deux années après la sanction royale de la *Loi de 2016 modifiant des lois en ce qui concerne l'aide médicale à mourir*, le ministre établit un protocole relativement à l'examen des dispositions du présent article.

Définitions

(5) Les définitions qui suivent s'appliquent au présent article.

«aide médicale à mourir» S'entend au sens de l'article 241.1 du *Code criminel* (Canada). («medical assistance in dying»)

«infirmière praticienne ou infirmier praticien» Infirmière

an extended certificate of registration under the *Nursing Act, 1991*; ("infirmière praticienne ou infirmier praticien")

"physician" means a member of the College of Physicians and Surgeons of Ontario. ("médecin")

EXCELLENT CARE FOR ALL ACT, 2010

2. (1) Section 1 of the *Excellent Care for All Act, 2010* is amended by adding the following definitions:

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada); ("aide médicale à mourir")

"nurse practitioner" means a registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*; ("infirmière praticienne ou infirmier praticien")

"physician" means a member of the College of Physicians and Surgeons of Ontario; ("médecin")

(2) The Act is amended by adding the following sections:

MEDICAL ASSISTANCE IN DYING

Immunity, MAID

13.8 (1) No action or other proceeding for damages shall be instituted against a physician or nurse practitioner or any other person assisting him or her for any act done or omitted in good faith in the performance or intended performance of medical assistance in dying.

Exception

(2) Subsection (1) does not apply to an action or proceeding that is based upon the alleged negligence of a physician, nurse practitioner or other person.

MAID has no effect on rights and benefits

13.9 (1) Subject to subsection (2), the fact that a person received medical assistance in dying may not be invoked as a reason to deny a right or refuse a benefit or any other sum which would otherwise be provided under a contract or statute.

Contrary intention

(2) Subsection (1) applies unless an express contrary intention appears in the statute.

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

3. Section 65 of the *Freedom of Information and Protection of Privacy Act* is amended by adding the following subsections:

Non-application of Act

(11) This Act does not apply to identifying information relating to medical assistance in dying.

autorisée ou infirmier autorisé qui est titulaire d'un certificat d'inscription supérieur délivré sous le régime de la *Loi de 1991 sur les infirmières et infirmiers*. («nurse practitioner»)

«médecin» Membre de l'Ordre des médecins et chirurgiens de l'Ontario. («physician»)

LOI DE 2010 SUR L'EXCELLENCE DES SOINS POUR TOUS

2. (1) L'article 1 de la *Loi de 2010 sur l'excellence des soins pour tous* est modifié par adjonction des définitions suivantes :

«aide médicale à mourir» S'entend au sens de l'article 241.1 du *Code criminel* (Canada). («medical assistance in dying»)

«infirmière praticienne ou infirmier praticien» Infirmière autorisée ou infirmier autorisé qui est titulaire d'un certificat d'inscription supérieur délivré sous le régime de la *Loi de 1991 sur les infirmières et infirmiers*. («nurse practitioner»)

«médecin» Membre de l'Ordre des médecins et chirurgiens de l'Ontario. («physician»)

(2) La Loi est modifiée par adjonction des articles suivants :

AIDE MÉDICALE À MOURIR

Aide médicale à mourir : immunité

13.8 (1) Sont irrecevables les actions ou autres instances en dommages-intérêts introduites contre un médecin ou une infirmière praticienne ou un infirmier praticien, ou quiconque lui apporte une aide, pour un acte accompli ou omis de bonne foi dans la prestation effective ou censée telle de l'aide médicale à mourir.

Exception

(2) Le paragraphe (1) ne s'applique pas aux actions ou instances pour cause d'allégation de négligence de la part d'un médecin, d'une infirmière praticienne ou d'un infirmier praticien, ou d'une autre personne.

Aucun effet sur les droits et avantages

13.9 (1) Sous réserve du paragraphe (2), le fait qu'une personne a reçu l'aide médicale à mourir ne peut être invoqué pour refuser d'accorder un droit, un avantage ou toute autre somme qui seraient autrement prévus aux termes d'un contrat ou en vertu d'une loi.

Intention contraire

(2) Le paragraphe (1) s'applique, sauf intention contraire manifeste de la loi.

LOI SUR L'ACCÈS À L'INFORMATION ET LA PROTECTION DE LA VIE PRIVÉE

3. L'article 65 de la *Loi sur l'accès à l'information et la protection de la vie privée* est modifié par adjonction des paragraphes suivants :

Non-application de la Loi

(11) La présente loi ne s'applique pas aux renseignements identificatoires se rapportant à l'aide médicale à mourir.

Interpretation

(12) In subsection (11),

"identifying information" means information that identifies a person or facility or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify a person or facility; ("renseignements identificatoires")

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada). ("aide médicale à mourir")

MUNICIPAL FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

4. Section 52 of the *Municipal Freedom of Information and Protection of Privacy Act* is amended by adding the following subsections:

Non-application of Act

(5) This Act does not apply to identifying information relating to medical assistance in dying.

Interpretation

(6) In subsection (5),

"identifying information" means information that identifies a person or facility or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify a person or facility; ("renseignements identificatoires")

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada). ("aide médicale à mourir")

VITAL STATISTICS ACT

5. Section 21 of the *Vital Statistics Act* is amended by adding the following subsection:

Exception

(7) Subsections (5) and (6) do not apply if the person has died after receiving medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada), and a coroner has been given notice of or information about the death under section 10.1 of the *Coroners Act* and determined that the death ought not to be investigated.

WORKPLACE SAFETY AND INSURANCE ACT, 1997

6. (1) Subsection 2 (1) of the *Workplace Safety and Insurance Act, 1997* is amended by adding the following definition:

"medical assistance in dying" means medical assistance in dying within the meaning of section 241.1 of the *Criminal Code* (Canada); ("aide médicale à mourir")

Interprétation

(12) Les définitions qui suivent s'appliquent au paragraphe (11).

«aide médicale à mourir» S'entend au sens de l'article 241.1 du *Code criminel* (Canada). («medical assistance in dying»)

«renseignements identificatoires» Renseignements qui permettent d'identifier une personne ou un établissement ou à l'égard desquels il est raisonnable de prévoir, dans les circonstances, qu'ils pourraient servir, seuls ou avec d'autres, à identifier une personne ou un établissement. («identifying information»)

LOI SUR L'ACCÈS À L'INFORMATION MUNICIPALE ET LA PROTECTION DE LA VIE PRIVÉE

4. L'article 52 de la *Loi sur l'accès à l'information municipale et la protection de la vie privée* est modifié par adjonction des paragraphes suivants :

Non-application de la Loi

(5) La présente loi ne s'applique pas aux renseignements identificatoires se rapportant à l'aide médicale à mourir.

Interprétation

(6) Les définitions qui suivent s'appliquent au paragraphe (5).

«aide médicale à mourir» S'entend au sens de l'article 241.1 du *Code criminel* (Canada). («medical assistance in dying»)

«renseignements identificatoires» Renseignements qui permettent d'identifier une personne ou un établissement ou à l'égard desquels il est raisonnable de prévoir, dans les circonstances, qu'ils pourraient servir, seuls ou avec d'autres, à identifier une personne ou un établissement. («identifying information»)

LOI SUR LES STATISTIQUES DE L'ÉTAT CIVIL

5. L'article 21 de la *Loi sur les statistiques de l'état civil* est modifié par adjonction du paragraphe suivant :

Exception

(7) Les paragraphes (5) et (6) ne s'appliquent pas si la personne est décédée après la réception de l'aide médicale à mourir au sens de l'article 241.1 du *Code criminel* (Canada) et qu'un coroner a reçu, en application de l'article 10.1 de la *Loi sur les coroners*, un avis ou des renseignements relatifs au décès et conclu que le décès ne devrait pas faire l'objet d'une investigation.

LOI DE 1997 SUR LA SÉCURITÉ PROFESSIONNELLE ET L'ASSURANCE CONTRE LES ACCIDENTS DU TRAVAIL

6. (1) Le paragraphe 2 (1) de la *Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail* est modifié par adjonction de la définition suivante :

«aide médicale à mourir» S'entend au sens de l'article 241.1 du *Code criminel* (Canada). («medical assistance in dying»)

(2) Part I of the Act is amended by adding the following section:

Medical assistance in dying

2.2 For the purposes of this Act, a worker who receives medical assistance in dying is deemed to have died as a result of the injury or disease for which the worker was determined to be eligible to receive medical assistance in dying in accordance with paragraph 241.2 (3) (a) of the *Criminal Code* (Canada).

COMMENCEMENT AND SHORT TITLE

Commencement

7. This Act comes into force on the day it receives Royal Assent.

Short title

8. The short title of this Act is the *Medical Assistance in Dying Statute Law Amendment Act, 2016*.

(2) La partie I de la Loi est modifiée par adjonction de l'article suivant :

Aide médicale à mourir

2.2 Pour l'application de la présente loi, le travailleur qui reçoit l'aide médicale à mourir est réputé être décédé par suite de la blessure ou de la maladie pour laquelle il a été reconnu admissible à recevoir l'aide médicale à mourir conformément à l'alinéa 241.2 (3) a) du *Code criminel* (Canada).

ENTRÉE EN VIGUEUR ET TITRE ABRÉGÉ

Entrée en vigueur

7. La présente loi entre en vigueur le jour où elle reçoit la sanction royale.

Titre abrégé

8. Le titre abrégé de la présente loi est *Loi de 2016 modifiant des lois en ce qui concerne l'aide médicale à mourir*.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **Quality Management Partnership: Proposed changes to the companion document '*Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy/Colonoscopy* - Role of the Medical Director'**

DATE: **February 24, 2017**

For Information

ISSUE:

- This note provides Council with information about the Quality Management Partnership's proposed addition of the Facility Lead role to the role of the OHP (Out of Hospital Premise) Medical Director for colonoscopy OHPs.
- Council is reminded the core standards for the Out of Hospital Premises Inspection Program (OHPIP) are not being re-opened to do this. Instead this role will be inserted into the companion document *Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy /Colonoscopy Premises*. As such, this item is brought to Council for information.

BACKGROUND:

- In December 2015 the Ministry of Health and Long-Term Care mandated that the Quality Management Partnership, a CPSO strategic initiative, start implementing Quality Management Programs (QMPs) in colonoscopy, mammography and pathology. This consists of four (4) components; developing provincial standards, clinical leadership, quality improvement resources and quality reports.
- The aim of embedding the Colonoscopy QMP Facility Lead role into the OHPIP companion document for colonoscopy is to assure OHPs are able to support the Partnership's goal of delivering quality care.
- A core component of the QMPs is its quality management model, consisting of three tiers of clinical accountability for quality at the provincial, regional and facility level.
- Another core component of the QMPs is quality management reports. Regular quality management reports include provincial, regional, facility and provider level reports. The purpose of these reports is to engage facilities and providers in discussions regarding quality and to identify opportunities for quality improvement. Facility level reports include facility standards and rolled-up clinical indicators, while provider level reports focus on clinical indicators for individual physicians.
- In the Fall of 2016, the Partnership distributed facility, regional and provincial quality reports in each of the health service areas. As the implementation of quality reporting continues, the Partnership will continue to leverage CCO's existing data and expand its data collection tools and resources to enhance the utility of the quality management reports.
- Facility Leads will be responsible for using reports to discuss quality improvement at the facility level, working with physicians, staff at the facility, and with Regional and Provincial Leads.
- As implementation of the Quality Management Programs progress, the Partnership is seeking to align the Colonoscopy QMP with our OHP inspection and assessment programs by embedding the role of the Facility Lead into the Medical Director role in the OHPIP companion document to the core Standards.

- Embedding the role of Facility Lead into the OHPIP companion document will help ensure the delivery of the QMP in OHPs and the goals of the Partnership, including that of fostering continuous quality improvement at the facility level. Based on facility and provider quality management reports, the Facility Lead will work with providers and staff at the facility on quality improvement initiatives, and liaise with Regional and Provincial Leads. Additionally, the proposed changes to the companion document will provide increased accountability for the Facility Lead to identify patient safety concerns related to the quality management reports; and coordinate action including a possible referral of concerns to the College.

CURRENT STATUS:

- A Working Group was formed to discuss how the duties of a Facility Lead in the colonoscopy QMP will be added to the existing Medical Director role in the Out-of-Hospital Premises, specifically to the companion document, Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy/Colonoscopy.

- The Working Group consists of Colonoscopy QMP Clinical Lead representatives and CPSO committee members who will also be involved in the implementation of the Facility Lead Standards. The members include:

    - Dr. David Morgan, Colonoscopy QMP Provincial Lead
    - Dr. Jonathan Love, Colonoscopy QMP Regional Lead
    - Dr. Bob Byrick , Premises Inspection Committee
    - Dr. Hugh Kendall, Premises Inspection Committee

- The working group agreed these activities should be embedded in the Medical Director role in OHPs as they have ultimate responsibility for the quality of care in their premises.

- PA&E staff reviewed and provided feedback on the proposed draft Facility Lead Standards (Appendix A). We have also obtained input from SMT and advice from College legal counsel which is represented in this briefing note.

- In October 2016 the Facility Lead role standards were presented to the Premises Inspection committee for information and were shared with for information with the Executive Committee on January 17th, 2017.

- The attached draft proposal (Appendix A) is for Council's reference and information. The following sections appear in the most recent Facility Lead Standards proposal:

<u>Section 5.1 OHP Medical Director Qualifications</u>
This section outlines the qualifications that a Facility Lead shall hold and indicates that whenever possible the Medical Director will be the Facility Lead at OHP. Not only should the Facility Lead maintain the same qualifications as the Medical Director but the Facility Lead must also actively have colonoscopy as part of their scope of practice. If the nature of the region of where they practice makes this not feasible, the scope of practice must include endoscopy. Additional considerations have been addressed in this section that address circumstances when the Medical Director is not the Facility Lead and for small facilities where there are less than three (3) colonoscopists. This is of particular importance when less than three (3) colonosopists practise in a facility to ensure they do not receive provider or facility level QMP reports to maintain privacy. To help minimize this risk, the Regional Lead will be responsible for receiving and reviewing provider and facility level reports at the OHP facility and will address quality improvement issues with providers as needed. This aligns with CCO's privacy requirements but with goals of transparency this will evolve as the program matures.

Section 8 Quality Assurance (QA) Standards
This section summarizes the activities the Facility Lead must be responsible for when acting as a liaison between OHP staff and the Partnership; as well as additional duties related to the receipt of facility and provider level reports and using the reports to help identify quality improvement opportunities. This section further demonstrates how the Facility Lead duties can be integrated into the OHP facility through the Medical Director role. By embedding the role of Facility Lead into the QA section, this will aid in ensuring that facilities have increased accountability for patient related quality improvement and assurance issues that may arise.

Section 8 Quality Assurance (QA) 8.2 and 8.3
This section further outlines the duties that a Facility Lead has when there are persistent and or serious deviations in clinical quality indicators and facility standards related to the Colonoscopy QMP reports which are not being met and result in patient safety concerns. Under these circumstances, the Facility Lead must communicate with the Medical Director to identify and document patient safety concerns and deviations in accordance with Quality Assurance reporting required by the Partnership, which is currently under development. This process correlates to the quality management reports and will not duplicate any efforts related to OHPIP adverse event requirements.

CONSIDERATIONS:

- Broader legislative and regulatory supports mandating that members participate in the Partnership programs are under consideration. In the interim, embedding the Facility Lead role in OHPIP companion document is a lever that can be used to ensure alignment with and participation in Partnership programs. This could result in PIC considering issues of adherence by the medical director to the Facility Lead role that may be identified through an inspection-assessment.

- When presented to PIC in October'16, some members of the committee expressed concern that issues with compliance with these standards may result in inappropriate action from the CPSO.

- OHP Medical Directors may require additional orientation regarding the Colonoscopy QMP Facility Lead once embedded in OHPIP. This is also true for CPSO assessors and PIC.

- Once embedded in OHPIP companion document the Facility Lead will be required to monitor and report to the College any patient safety concerns resulting from persistent and or serious deviations in adherence to the Colonoscopy QMP facility standards and clinical quality indicators. The definition and triaging of these concerns is under development by members of the Partnership's Colonoscopy Provincial Quality Committee and will not duplicate the OHPIP adverse events reporting requirement.

- As a result of the cancellation of a Ministry of Health and Long-Term Care payment scheme for OHPs performing colonoscopy to become licensed as IHFs, some owners and Medical Directors of these OHPs have declined to participate fully in the Partnership quality management program. The thrust of their position being there will be additional costs associated to implement the quality management program. This position is supported by individuals as well as the Ontario Association of Gastroenterologists, Ontario Association of General Surgeons, the Ontario Association of Clinical Endoscopists.

NEXT STEPS:

- Once reviewed by Council, the attached version of the Facility Lead Standards will be shared with key stakeholders for a 30 day targeted consultation to be completed by May, 2017. Results will be considered by the colonoscopy standards working group and College governance prior to being finalized.

DECISION FOR COUNCIL:

For information.

Contact: Robin Reece, ext. 396
Wade Hillier, ext. 636

Date: February 24, 2017

Appendices: Appendix A: Proposed Colonoscopy QMP Facility Lead Standards

Appendix A

January 17th, 2017

Colonoscopy Quality Management Program Facility Lead

Background

In March 2013, the Ministry of Health and Long-Term Care (MOHLTC) established the Quality Management Partnership (the Partnership) with the purpose of designing quality management programs in colonoscopy, mammography, and pathology. Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO) lead this initiative. On December 1, 2015 the Ministry of Long Term Care (MOHLTC) mandated that the Partnership start implementation of quality management programs (QMPs) in all three health service areas. An integral component of a QMP is to identify appropriate clinical and administrative contacts in each facility that will champion and be responsible for fostering continuous quality improvement.

The clinical leadership structure of the QMPs consists of a network of clinical leads at the provincial, regional and facility levels. The colonoscopy QMP has a Provincial Quality Committee (PQC) that oversees overall quality and accountability at all levels. The Facility Lead will work collaboratively with the Regional Lead to support continuous quality improvement within each facility/OHP.

Role of the colonoscopy quality management program Facility Lead

As outlined in the OHPIP Program Standards, it is an expectation that facilities must have a Medical Director, to satisfy the requirements of the OHPIP core Standards and a Facility Lead to satisfy the requirements of the colonoscopy QMP.

January 17th, 2017

The Facility Lead is responsible for quality management and improvement activities within the facility (OHP) as it relates to QMP reports. The Medical Director is responsible for overall quality assurance within the OHP.

5.1 OHP Medical Director Qualifications

Guidance to the Standard

OHP Medical Director Qualifications, Standard 5.1. In addition to the Medical Director qualifications, the Facility Lead's scope of practice must include colonoscopy. If the nature of the region of where they practice makes this not feasible, the scope of practice must include endoscopy.

5.1 OHP Medical Director Qualifications

A physician who is applying to become a Medical Director must hold a valid CPSO certificate of registration and must ***not*** be the subject of any disciplinary or incapacity proceeding in any jurisdiction.

If, during the course of serving as a Medical Director, the Medical Director becomes the subject of a disciplinary or incapacity proceeding, the Medical Director must inform the Out-of-Hospital Premises program staff at the CPSO, and may be required to appoint a substitute Medical Director at the discretion of the CPSO. The Medical Director may only resume the role upon CPSO approval.

The OHP must have a Medical Director appointed at all times. Failure to have an appointed Medical Director will result in an outcome of Fail.

5.2 Physician Performing Procedures Qualifications

All physicians who perform procedures using local anesthesia in OHPs, as set out in O. Reg. 114/94, shall hold:

1) Valid CPSO certificate of registration

And

2) a) One of the following: RCPSC or CFPC certification that confirms training and specialty designation pertinent to the procedures performed.

b) CPSO recognition as a specialist that would include, by training and experience (the procedures performed (as confirmed by the CPSO "Specialist Recognition Criteria in Ontario" policy.

c) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Note:

1. Wherever possible, it is preferred that the Medical Director of an OHP assume the role of the Facility Lead. If the qualification criteria for a Facility Lead cannot be met by the Medical Director, then the Medical Director must work with the Regional Lead to appoint and document an appropriate Facility Lead who has colonoscopy within their scope of practice. If the nature of the region of where they practice makes this not feasible, the scope of practice must include endoscopy. CPSO must be informed of the change.
2. In situations where there is a multi-site facility, each site does not need a separate Facility Lead and the Facility Lead must be performing colonoscopy procedures in at least one of the sites.
3. The Facility Lead is accountable to the Medical Director and must participate in and document regular communication with the Medical Director regarding quality management and improvement activities and findings.

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4. In small facilities i.e. where there are two or three colonoscopists practicing at the facility, the Regional Lead will receive and review provider and facility level QMP reports with the providers at the facility in order to maintain privacy and confidentiality of individual provider level data.

8. Quality Assurance
Guidance to the Standard:
Section 8 Quality Assurance (QA)
Standards 8.1

In addition to the core OHP Standards the Facility Lead must be responsible for the following QA responsibilities:

- Receiving Partnership information and acting as a liaison between OHP staff and the Partnership including:
  - Communicating with facility staff about tools, guidelines or other initiatives related the Colonoscopy QMP and documenting any feedback.
  - Providing Facility Lead and Medical Director names, addresses, email addresses and telephone numbers to the Partnership and completed surveys related to the Colonoscopy QMP.

- Tracking that the OHP has received facility and provider level Colonoscopy QMP reports from the Partnership (Cancer Care Ontario) by:
  - Reviewing and documenting Partnership reports with appropriate staff.
  - Identifying and documenting issues and opportunities for quality improvement (QI)
  - Developing and documenting a QI plan to address opportunities for improvement with the OHP staff.

8 Quality Assurance (QA

The Medical Director is responsible for OHP compliance with external regulatory requirements including all Acts relevant to the practise of Medicine[1], including the CPSO OHP Standards, Companion documents to the Standards, and other guidelines, such as, the Provincial Infectious Diseases Advisory Committee's (PIDAC) *Infection Prevention and Control for Clinical Office Practice*, Malignant Hyperthermia Association of the United States (MHAUS), etc. The Medical Director is also individually responsible for OHP compliance with all internal CPSO policies, guidelines and directives within their Policy and Procedure Manual.
The Medical Director is responsible for appointing other individuals as necessary to **assist** with OHP staff compliance with policies and procedures set out by the Medical Director, especially as it relates to monitoring and reporting on the quality of anesthetic and surgical procedures.

OHP Quality Assurance Committee

Each OHP must have a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance so that the care provided will satisfy requirements as appropriate to the volume and scope of service provided.

The Medical Director must attend and chair, at a minimum, two QA Committee meetings at each OHP site, per year. Meetings must include representation from all staff providing patient care for every type of anesthetic or surgical procedure. All meetings must be documented. The documentation of the QA Committee meetings must be available upon request by the Premises Inspection Committee and be available for OHP assessors to review.

At minimum, every QA Committee meeting must address the following topics:
1) Reports on Quality of Care for each service (8.1)
2) Infection Control– duties as set out in Section 7
3) Adverse Events
4) Staffing credentials

8.1 Monitoring Quality of Care
The purpose of monitoring activity is to identify problems and frequency, assess severity, and develop remedial action as required to prevent or mitigate harm from adverse events.

Monitoring OHP Activity
The OHP must have a documented process in place to regularly monitor the quality of care provided to patients. These activities include, but are not limited to, the following:

1) Review of non-medical staff performance
2) Review of individual physician care to assess
a) patient and procedure selection are appropriate
b) patient outcomes are appropriate
c) adverse events (see8.2)
The suggested protocol is, annually, random selection 5-10 patient records to review:
i) records completion and documentation of informed consent
ii) percentage and type of procedures
iii) appropriate patient selection
iv) appropriate patient procedure
v) where required, reporting results in a timely fashion
vi) evaluation of complications (see 8.2)
vii) assessment of transfer to hospital, where required
viii) follow up of abnormal pathology and laboratory results
3) Review a selection of individual patient records to assess completeness and accuracy of entries by all staff
4) Review of activity related to cleaning, sterilization, maintenance, and storage of equipment
5) Documentation of the numbers of procedures performed: any significant increase/decrease
(>50% of the last reported assessment

- Documenting the implementation of the QI plan with the facility and staff.

Section 8 Quality Assurance (QA)
Standards, 8.2 and 8.3 – In addition to these Standards the Facility Lead role must be responsible for the following additional responsibilities:

- The Facility Lead must act on and report to the Medical Director and Regional Lead any persistent and or serious deviations where provider level quality indicators and facility level quality standards reflected in QMP reports are not being met.

- The Facility Lead must communicate with the Medical Director, to identify and document patient safety concerns and any persistent and or serious deviations in the provider level indicators and or facility level quality standards, in accordance with processes required by the Partnership.

- The Facility Lead in coordination with the Regional Lead must make any decisions about referring patient safety concerns to the CPSO in a timely way and document all decisions made in accordance with Partnership processes.

8.2 Monitoring and Reporting Adverse Event

1. All OHP staff must monitor adverse events. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure.
2. Every member who performs a procedure in an OHP shall report the following events to the College within 24 hours of learning of the event. These events are termed 'Tier 1 Events' to denote the potential serious nature of the event and the need to prevent a recurrence.

Tier 1 events are:

a) Death within the premises;
b) Death within ten (10) days of a procedure performed at the premises;
c) Any procedure performed on the wrong patient, site or side; or,
d) Transfer of a patient from the premises directly to a hospital for care.

3. Members performing procedures in an OHP are required to document other quality assurance incidents (Tier 2) which are deemed less critical for immediate action. The premises' QA Committee and the Medical Director must submit Tier 2 events to the College after review (on an annual basis). Failure to do so may result in an outcome of Fail by the Premises Inspection Committee.

Tier 2 events include, but are **not limited to**:

a) unscheduled treatment of a patient in a hospital within ten (10) days of a procedure performed at a premises
b) complications such as infection, bleeding or injury to other body structures
c) cardiac or respiratory problems during the patient's stay at the OHP
d) allergic reactions
e) medication-related adverse events

4. All OHP staff should report adverse events as follows:

4.1 The member must report Tier 1 adverse events (see above) to the Medical Director and to the College in writing within 24 hours of learning of the event using the form provided on the College website. To access the form, the reporting physician must log in to his/her CPSO member portal on the CPSO website at https://www.cpso.on.ca/Login.aspx

4.2 Death occurring within the OHP must also be reported to the coroner.

4.3 The member should report in writing any Tier 2 adverse event (see above) to the Medical Director within 24 hours of the event. The written report should include the following:

a) Name, age, and sex of the person(s) involved in the incident, includes staff and patients
b) name of the witness(es) to the event (if applicable)
c) time, date and location of the event
d) description of the incident and treatment rendered
e) date and type of procedure (if applicable)
f) analysis of reasons for the incident
g) outcome.

Note: OHPs should identify and adherence to quality indicators specific to procedures performed in their premises.

8.3 Review of Adverse Events and other QA Monitoring Activities

The Medical Director must:

1) Review all adverse events reports and QA monitoring findings occurring over a 12 month period
2) Document the review and any relevant corrective actions and quality improvement iniatives taken
3) Provider feedback to all staff regarding identified adverse events.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **GOVERNMENT RELATIONS REPORT**

DATE: **FEBRUARY, 2017**

FOR INFORMATION

Items:
1. Ontario's Political Environment
2. Legislative Issues of Interest
3. Government Relations Activities

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1. Ontario's Political Environment

- The fall session of the Ontario Legislature rose on December 8, 2016 and the spring session is scheduled to begin on February 21, 2017.
- The next provincial election is only 16 months away, scheduled for June 7, 2018. The Liberal government is struggling to reverse the Premier's approval rating that has been hovering around 14% since the summer of 2016.
- In the past two years, there have been 6 by-elections held in Ontario. Although the Liberals won the first seat, electing Glen Thibeault in February 2015, the PCs were on a winning streak until the Liberals held onto Ottawa-Vanier with Nathalie Des Rossiers' win in November 2016. With the December 2016 resignation of long-serving Sault Ste. Marie Liberal MPP and Minister of Community Safety and Corrections, David Orazietti, the Premier will have to call another by-election by June 30, 2017.
- Ontario's rising hydro costs has been a primary focus in Ontario politics, particularly over the past year. Both opposition parties have made the rising cost of hydro a focus of their efforts at Queen's Park and it is widely considered to be a primary factor in the Liberal's by-election losses.
- In the fall of 2016, the Liberal government committed to making hydro bills more affordable for Ontarians. As of January 1st, the government began waiving the provincial portion of the HST on hydro bills; an 8 per cent drop. This is expected to save the average customer $11 a month or $130 a year.
- Affordability issues, more generally, as well as concerns over health care – specifically hospital funding, and the ongoing negotiations with Ontario's doctors – have also dominated at Queen's Park and beyond.
- There is no question that Wynne's Liberals are facing a significant uphill battle if they have any chance of holding onto power post June 2018. Ontario's Liberal Party has been in power for almost 14 years – a remarkable feat.

- The Premier has clearly stated that she has no intention of stepping down prior to the next election.
- As evidenced by the Premier's recent decision to reject Mayor John Tory's proposal for tolls on Toronto's highways, Ontario has already entered into unofficial election mode. We can anticipate that it will continue to be an active and rocky year for Ontario politics both at Queen's Park and beyond with all three parties determined to enter into the official campaigning period with an increased showing in the polls.
- The PCs are currently leading in the polls yet leader Patrick Brown remains largely unknown to Ontarians and ongoing questions about the leader's and party's ties with social conservatives leave them vulnerable to criticism from both the left and the right. Translating their current lead in the polls to a win in June 2018 is by no means a *fait accomplit*.

2. Legislative Issues of Interest

- The previous session was relatively busy in regards to legislation that will broadly impact health care in Ontario. Legislation of particular interest to the College are summarized below:

Bill 41, Patient First Act

- *Bill 41, Patients First Act, 2016* passed third reading and received Royal Assent on December 8, 2016.
- *Bill 41* expands the role of Ontario's Local Health Integration Networks (LHINs) to include home and community care, and provide the LHINs with the authority to manage and monitor primary care directly. The Bill also expands the role of the Minister of Health and Long-Term Care and transfers the operations of Community Care Access Corporations (CCACs) to the LHINs.
- Strong opposition to Bill 41 has been voiced by the OMA. They have accused the government of making unilateral changes to the health care system without collaborating with doctors and increasing bureaucracy instead of front-line care.

Bill 87, Protecting Patients Act

- At the end of the last legislative session, two Bills were introduced that the College had been anticipating: *Bill 87, the Protecting Patients Act, 2016* and *Bill 84, Medical Assistance in Dying Statute Law Amendment Act, 2016.*
- Bill 87 is an omnibus health bill that, among other measures, contains the government's response to the recommendations made by the Minister's Sexual Abuse Task Force. Schedule 4 of the Bill sets out a number of amendments to the *Regulated Health Professions Act*.
- Major elements of the Bill include:
    - Increased Ministerial powers including a broad new regulation-making authority that would allow the Minister to make regulations with respect to all aspects of the structure of Colleges' statutory committees including: composition, panel quorum, eligibility requirements and disqualification grounds;
    - Expanding the list of acts of sexual abuse in the Code that will result in mandatory revocation;
    - A new definition of the term patient for the purposes of the sexual abuse

provisions of the Code; and
    - Amending the Code so that a discipline panel is prevented from ordering gender-based restrictions in any case (not just sexual abuse cases).
- An overview and analysis of the Bill can be found in a separate briefing note.
- This Bill is significant for the College with implications for all areas of the institution including every statutory committee, College bylaws and more.
- It will be the area of central focus in College government relations activity this year.
- We anticipate that second reading debate on Bill 87 will occur in the spring session, scheduled to begin on February 21st.
- The speed by which the Bill will progress through the legislative processes of second reading debate, Committee hearings, third reading and Royal Assent are unknown at this time. Information will be shared as it becomes available.
- We hope to be able to share our analysis of Bill 87 with government and the opposition parties early in the new legislative session.

Bill 84, the Medical Assistance in Dying Statute Law Amendment Act

- *Bill 84, the Medical Assistance in Dying Statute Law Amendment Act, 2016* provides greater clarity and protections on a range of issues related to MAID that fall under provincial jurisdiction. It amends six existing statutes and aligns with federal MAID legislation. The changes proposed in Bill 84 are largely of a "housekeeping" nature.
- Council is provided with more detailed information on Bill 84 in a separate briefing note.
- We will closely monitor the Bill's progress through the legislative process and keep Council informed.

3. Government Relations Activities

- The College has frequent regular contact with all levels of government decision-makers to ensure government and elected officials have accurate and up-to-date information about the College and our activities.
- We have worked particularly closely with government on areas of shared focus including sexual abuse, the implementation of MAID, government management of the public appointment process, transparency, the regulation of fertility services, the overhaul of out-of-hospital facility regulation, and issues surrounding opioids and medication management.
- We regularly meet with MPPs from all three parties.
- We anticipate a very busy spring session and a full and active government relations agenda for the College in 2017.

CONTACT: Louise Verity: 416-967-2600 x466
Miriam Barna: 416-967-2600 x557

DATE: February 3, 2017

Discipline Committee
Report of Completed Cases - February 2017

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between November 9, 2016 and February 3, 2017. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse / Sexual Impropriety – 7 cases

1. Dr. R.F. Anastasio, Jr.

Name:	Dr. Romulo Fanio Anastasio, Jr.
Practice:	Family Medicine
Practice Location:	Hamilton
Hearing:	Uncontested Facts and Penalty
Decision Date:	November 1, 2016
Written Decision Date:	December 15, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Contravened a term, condition and limitation on certificate of registration - **proved**
- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Anastasio Jr. held a certificate of registration with the College from 1981 to 2016, when he resigned his membership.

Patient A

Patient A became Dr. Anastasio's patient when she was an infant. She saw him as her family doctor until she was in her late 20s.

In the fall of 2007, when Patient A was in her late 20s, she attended Dr. Anastasio's office for her annual physical and Dr. Anastasio performed an internal exam.

Dr. Anastasio told Patient A he was concerned about a possible HPV infection because her cervix appeared red. Dr. Anastasio advised her that HPV infections could lead to cervical cancer and requisitioned a genital culture pap smear to investigate these concerns. He told her he wanted to keep track of this with regular visits.

At that appointment, Dr. Anastasio told Patient A he wanted to monitor her closely. He gave her his pager number so that she could reach him whenever she wanted. Dr. Anastasio asked Patient A to provide him with her cell phone number, so that she could be kept up-to-date on the matter. Patient A gave Dr. Anastasio her cell phone number as she was grateful that her doctor appeared concerned for her health.

After this encounter, Dr. Anastasio called Patient A several times on her cell phone to come to the clinic for follow-up. He asked her to come to the clinic after 5 p.m. Although she understood that his office was closed at this time and she had never attended his office after 5 before, she trusted Dr. Anastasio, and so she complied with his request.

Patient A arrived at Dr. Anastasio's office in the early evening in the fall of 2007. No one else was present at the office at that time. Dr. Anastasio showed her around the clinic space and pointed to a couch at the rear of the clinic where he advised her he sleeps if he needs to.

Dr. Anastasio brought Patient A into an examination room and told her he was pleased she was staying on top of the issue; and not to be concerned, he wanted to ensure it was not something leading to cancer.

Dr. Anastasio told Patient A he wanted to examine her to see if the redness was spreading. Dr. Anastasio asked her to undress from the waist down. Dr. Anastasio gave Patient A a sheet to cover herself and left the examination room while she got undressed. Dr. Anastasio sat on a stool at the foot of the examination table and asked Patient A to move her buttocks to the edge of the examination table. He inserted a speculum and examined Patient A's vaginal area. He removed the speculum and stood up from the stool. As he stood up, Dr. Anastasio pressed his groin area onto Patient A's naked genital area.

Dr. Anastasio then stood next to Patient A while she lay on the examination table. He removed his gloves. Without warning, with his bare hands, he took her hand and pushed it into her vagina. He told her he wanted her to feel her cervix and know where it is. Pushing Patient A's hand into her vagina served no legitimate medical purpose.

Dr. Anastasio maintained no clinical record of this patient encounter.

Following that evening, Dr. Anastasio continued to call Patient A requesting that she return to his office for further examination after hours. On one occasion, Dr. Anastasio called Patient A while she was at home and she became angry and threw the phone on the kitchen table. At that time, her mother made inquiries and she disclosed to her mother what had happened. Her mother disclosed this to her doctor, who then reported the incident to the College.

Breach of prior Discipline Committee Order

Dr. Anastasio was the subject of a prior discipline proceeding at the College in which he was found to have engaged in disgraceful, dishonourable, and unprofessional conduct in respect of two patients. He was found to have kissed a patient during a medical appointment and he was found to have made inappropriate comments to another patient, as well as brushing his hand against her bottom area.

On June 15, 2012, the Discipline Committee of the College imposed terms, conditions, and limitations on Dr. Anastasio's certificate of registration, requiring that Dr. Anastasio shall:

- provide a written notice to each female patient he sees in a form advising each female patient of the Order and the findings in the proceeding., appending a copy of the Decision and Reasons when released, and advising the patient that the College may contact them to inquire about their treatment by Dr. Anastasio. Dr. Anastasio shall ensure before providing treatment to a female patient that she signs this written notice to acknowledge she has reviewed the Order and Decisions and Reasons (when released); and
- keep this signed document in the corresponding patient file.

On November 12, 2013, a College investigator conducted an inspection of Dr. Anastasio's practice, and noted that although Dr. Anastasio was providing female patients with copies of appendix C to the Order as required and another written document, he was not providing patients with a copy of the July 6, 2012 Decision and Reasons of the Discipline Committee, nor was Dr. Anastasio appending copies of the Decision and Reasons and the Order to the Appendix "C", as required.

The written document that Dr. Anastasio was providing to female patients stated: "In 2009, two female patients reported me to the College with the following accusations: one said that I tried to kiss her and the other said that she felt my hand on her behind after I scolded her for her sexuality and after doing a pap test on her. I pleaded "no contest" as this was the advice given to me when I stated that I wanted the least disruption to my personal life as well as the running of the office. The College made their judgment based on the "no contest" plea and this [sic] are the results: 1) That I was suspended for two months; 2) I have to make sure I have signs in the waiting room as well as all the examination rooms that I cannot do pap, breast or rectal examinations without the presence of a chaperone duly approved by the College; 3) I also must have all female patients I am seeing for the first time after my suspension sign a form saying they are aware of the accusations against me, as well as the judgment of the College and the limitations imposed on me and the way I practice and that this signed form will be kept with you [sic] medical records; 4) If a female patient expresses unease on seeing me by herself, the office has to provide a chaperone duly approved by the College. The College may contact you re the above. I thank you for your continued trust and support."

Dr. Anastasio told the College Investigator that this written document had been prepared by his lawyer for him to show his patients. In fact, contrary to his statement to the College Investigator, Dr. Anastasio prepared the written document himself.

Dr. Anastasio told the College Investigator that his lawyer had not provided him with a copy of the Decision and Reasons which he was required to give to his female patients. In fact, Dr. Anastasio had been provided with a copy of the Decision and Reasons on July 9, 2012, and there was nothing preventing him from providing the Decision and Reasons to his female patients in accordance with the terms of the Order.

On November 28, 2013, Dr. Anastasio sent a letter to the College confirming that he had modified his practice to comply with the Order. A subsequent compliance visit

revealed that on two occasions, Dr. Anastasio failed to attach a copy of the Order and the Decision and Reasons to the patient acknowledgement as required by the Order, although the two patients confirmed having read both the Order and the Decision and Reasons.

Disposition

On November 1, 2016, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Anastasio's certificate of registration effective immediately.
- Dr. Anastasio reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, and shall post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within thirty (30) days of the date this Order becomes final, in the amount of $16,060.00.
- Dr. Anastasio appear before the panel to be reprimanded within 60 days of the Order becoming final.
- Dr. Anastasio Jr. pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date this Order.

2. Dr. R.S. Crozier

Name:	Dr. Robert Samuel Crozier
Practice:	Psychiatry
Practice Location:	London
Hearing:	Uncontested Facts and Joint Submission on Penalty
Decision Date:	October 17, 2016
Written Decision Date:	December 12, 2016

Allegations and Findings

- Engaged in sexual abuse of patients - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Found guilty of offence relevant to suitability to practice – **proved**

Summary

Dr. Robert Crozier, a physician with a specialty in psychiatry, practised in London, Ontario.

Patient A

Patient A began seeing Dr. Crozier for psychiatric care in 2007 and attended appointments with him regularly until 2013. Dr. Crozier diagnosed Patient A with depression.

At the end of an appointment in December 2013, Dr. Crozier and Patient A hugged while sitting on the couch within the office. Dr. Crozier then fondled Patient A's breast. Dr. Crozier stopped for a short time. He then moved his hands up inside of Patient A's shirt and began fondling her breasts and nipple. He asked her if she liked this, to which she stated "No." Dr. Crozier then asked if she had experienced an orgasm before, advising that it relieved stress.

Patient A then left the couch, stood up, and put her coat on. As Patient A was leaving the office, she told Dr. Crozier she was uncomfortable about what had occurred, at which time he apologized and stated that he had made a huge mistake. Patient A then left the office, returned home, and subsequently reported the incident to the police, who investigated the matter.

The police interviewed Dr. Crozier later on in December 2013, wherein he admitted to several aspects of this incident. Dr. Crozier was accordingly arrested for sexual assault. Dr. Crozier was released with conditions including that he not contact Patient A.

Later that day, when Patient A was at home, she received a phone call from a number that Patient A recognized as being the number of the Dr. Crozier's workplace at about 6:46 p.m. Patient A did not answer this call and Dr. Crozier's voice was subsequently heard to be leaving a message for her. Over the next two hours, Dr. Crozier proceeded to contact Patient A ten more times, leaving five more voice messages for her begging for forgiveness. This was in violation of his release conditions.

On October 9, 2014, Dr. Crozier pled guilty to the sexual assault of Patient A. He was sentenced to four months in custody and probation for two years. Dr. Crozier was further required to comply with the Sexual Offender Registry for a period of ten years.

Patient B

Patient B regularly saw Dr. Crozier for psychiatric care between 2005 and 2013. In September 2013, Dr. Crozier provided Patient B with diagnoses including anxiety and depression.

In 2013, Patient B attended Dr. Crozier's office for a scheduled appointment. During the appointment, Dr. Crozier asked Patient B if she wanted a hug. Dr. Crozier came over to Patient B and sat down on the couch next to her. Dr. Crozier hugged Patient B and touched her breast with his hand. Dr. Crozier then hugged Patient B again and touched her breast with his hand again. Patient B attempted to brush away Dr. Crozier's hand.

Dr. Crozier told Patient B that she had been through so much and that he wanted to give her another hug. Dr. Crozier indicated that he was thinking that Patient B could take off her top. Patient B replied that she felt this was highly inappropriate.

Patient B told Dr. Crozier that she needed to get going as she had a pot roast on for dinner, but that she needed a new prescription. Dr. Crozier told Patient B that he hoped she could forgive him if he had been inappropriate.

Patient B returned home and told her husband what had transpired. Her husband called Dr. Crozier's office asking for a call back. Dr. Crozier returned her husband's call and admitted to "crossing the line" with Patient B. Dr. Crozier called back shortly thereafter on two occasions, apologizing and inquiring if Patient B would return to see him. Dr. Crozier subsequently left two voice messages at Patient B's home, apologizing and attempting to explain his behaviour.

Patient C

Patient C first met Dr. Crozier on a date in 1993 further to a referral from her family physician. Dr. Crozier saw Patient C for regular appointments until 2000 and prescribed medications to Patient C to address her anxiety.

In 1997, Dr. Crozier's child was born with serious health problems. Around this time, Patient C offered comfort to Dr. Crozier. He accepted, holding her hand and sitting beside her on the couch during her sessions. Dr. Crozier also accepted comforting touches on the shoulder from Patient C on at least one occasion.

Dr. Crozier accepted Patient C's offer to speak about his stress and he did so, discussing his child's health, the impact upon him (including his use of alcohol) and other aspects of his personal life, including his marital difficulties. During these discussions, Dr. Crozier sat beside Patient C and held her hand while they talked. This occurred at several appointments in 1997.

Over the course of the next two years, Patient C advised Dr. Crozier that she had developed feelings for him. Patient C attended unannounced at Dr. Crozier's home on two occasions. Dr. Crozier did not take steps to discharge Patient C from his practice until 2006.

Dr. Crozier ceased practising in 2000 for about two years due to alcohol abuse. Prior to the completion of treatment for his substance abuse disorder, Patient C asked Dr. Crozier for money. Patient C told Dr. Crozier that she needed money because her family was not doing well financially. She threatened to report Dr. Crozier to the College for his boundary crossings with her in 1997 and for his alcohol use if Dr. Crozier did not provide her with money.

Dr. Crozier provided Patient C with several thousand dollars in 1997. Thereafter Patient C continued to threaten Dr. Crozier and ask him for money. He continued to pay her with the exception of two years until the fall of 2013. Dr. Crozier estimates having paid Patient C a total of approximately $150,000.00.

Dr. Crozier received residential treatment for alcohol abuse (substance abuse disorder) in 2000 and 2001. He returned to the practice of medicine in the middle of 2002. Upon his return to practice, Dr. Crozier saw Patient C for appointments from July 2002 to September 2006.

The allegations with respect to Patient C came to the College's attention in July of 2014 through a third party.

Disposition

On October 17, 2016, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Crozier's certificate of registration, effective immediately.
- Dr. Crozier reimburse the College for funding provided to Patient A and B under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, by November 17, 2016, in the amount of $32,120.00.
- Dr. Crozier appear before the panel to be reprimanded.
- Dr. Crozier pay costs to the College in the amount of $5,000.00 by November 17, 2016.

3. Dr. Z. Margaliot

Name:	Dr. Zvi Margaliot
Practice:	Plastic Surgery
Practice Location:	Mississauga
Hearing:	Uncontested Facts and Penalty
Decision Dates:	September 19 and 22 2016
Written Decision Date:	December 22, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Margaliot, who has held a certificate of registration authorizing independent practice in Ontario since 2005, is certified by the Royal College of Physicians and Surgeons of Canada as a specialist in plastic surgery, and practices medicine as a hand surgeon.

Patient A was referred to Dr. Margaliot for recurring wrist pain and was first treated by him in March 2009. At the time, Patient A was twenty-two years old and an undergraduate student.

Between March 2009 and June 2010, Dr. Margaliot treated Patient A on ten occasions, including performing two surgeries on her right wrist.

In April 2010, while still engaged in a doctor-patient relationship, Patient A sent Dr. Margaliot a friend request via Facebook, which Dr. Margaliot accepted.

In June 2010, at the last post-operative appointment following her second wrist surgery, Dr. Margaliot stated in his clinical record that he would be happy to see Patient A back if she had any concerns.

In August 2010, Patient A contacted Dr. Margaliot through Facebook. Shortly thereafter, the two began to correspond by email.

In October 2010, Patient A invited Dr. Margaliot for coffee. Dr. Margaliot proposed a meeting place, and the two met for coffee. The two continued to exchange emails of a sexual nature.

On a date in December 2010, Patient A emailed Dr. Margaliot as follows: “Zvi, my wrist is killing me.. its bad enough I can barely use a speculum because its so weak...
a) Is this anything physio might fix (friend’s suggestion)
b) is it still appropriate for you to be my physician and
c) is there anything else we can do for this because it hurrrrts”

Dr. Margaliot replied:
“R or L wrist PT is usually not indicated until you a) have a diagnosis and b) it is something amenable to PT. I can look at it for you next week. Call Zohra ...”

Dr. Margaliot then asked "why, are you over-using your wrist?" and she replied "you’d like that wouldn’t you.” Dr. Margaliot treated Patient A in his office practice on a date in January 2011. On a date later on in January 2011, the two met for coffee. After this meeting, the two began texting. Some of the texts were of a sexual nature.

In February 2011, the two met for coffee and kissed. They met two days later in his office, in the evening, and engaged in kissing and touching of a sexual nature. In early March 2011, following a sexually explicit Gchat communication, the two met in the on-call room of the Hospital and had intercourse.

Dr. Margaliot treated Patient A again on a date in March 2011. He examined her for 50 minutes. At that appointment, she signed a consent for a third surgery, this time on her left wrist.

Subsequently, in close proximity to the appointment, while still engaged in a physician• patient relationship, the two had sexual intercourse, including in his office.

Her surgery did not proceed. The two continued to have a secret sexual affair, on again and off again, in 2011 and 2012.

Disposition

On September 19, 2016, the Discipline Committee ordered that Dr. Margaliot's certificate of registration be revoked, effective immediately.

On September 22, 2016, the Discipline Committee further ordered and directed that:

- Dr. Margaliot reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within thirty (30) days of the date this Order becomes final, in the amount of $16,060.00;
- Dr. Margaliot appear before the panel to be reprimanded; and
- Dr. Margaliot pay costs to the College in the amount of $15,000.00 within thirty (30) days of the date this Order becomes final.

4. Dr. W. L. Muirhead

Name:	Dr. William MacLaren Muirhead
Practice:	Family Medicine
Practice Location:	Waterloo
Hearing:	Contested
Decision Date:	May 17, 2016
Written Decision Date:	November 14, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Muirhead treated Patient A, a university student, between September 2008 and December 2011 after she was referred by university student health services for management of anxiety and depression.

Patient A's visits with Dr. Muirhead were frequent, taking place multiple times per week. Some appointments lasted more than two hours. At first, Dr. Muirhead would ask Patient A to sit on a chair close to his so that their knees would touch. The sessions would end with a hug. Dr. Muirhead encouraged Patient A to be dependent upon him. Their sessions then moved primarily to the back room of Dr. Muirhead's office, which had a mattress on the floor and a desk against the wall. Initial removal of Patient A's shirt and back massaging progressed to cuddling, digital penetration of her vagina on most visits, and sexual intercourse. Dr. Muirhead and Patient A spent most of the time in these sessions in the back room.

When Dr. Muirhead learned of the College's previous investigation of him, he warned Patient A in an email chat not to tell the College about any activities in the "back room." Dr. Muirhead instructed Patient A to explain his statement in emails to her of "I love you," as "I love you like he loved his dogs." Patient A did as Dr Muirhead requested, and did not initially admit to a sexual relationship with him despite being asked by the College investigator. Dr. Muirhead told Patient A that so many people, including her, were dependent on him. He convinced her that action by the College against him would ruin her life and her marriage. Patient A was also concerned about Dr. Muirhead's "explosive" reaction if she were to tell the College the truth.

Patient A estimated that Dr. Muirhead gave her a total of $23,000.00 over time.

Disposition

On May 17, 2016, the Discipline Committee ordered and directed that:

- the Registrar revoke Dr. Muirhead's certificate of registration effective immediately;
- Dr. Muirhead reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, by July 31, 2016, in the amount of $16,060.00; Dr. Muirhead appear before the panel to be reprimanded within 90 days of this Order becoming final; and
- Dr. Muirhead pay costs to the College in the amount of $10,000.00 by October 31, 2016.

5. Dr. R. J. Sekhon

Name:	Dr. Rajinder Singh Sekhon
Practice:	Independent Practice
Practice Location:	Ajax
Hearing:	Uncontested Facts and Penalty
Decision Date:	October 12, 2016
Written Decision Date:	December 9, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct - **proved**
- Incompetence - **proved**

Summary

Dr. Sekhon is a family physician who received his certificate of registration authorizing independent practice in 1989. He has practised in Windsor, Toronto, Tecumseh, and Ajax.

Patient A

Patient A became Dr. Sekhon's patient in 2009 and in that year, Dr. Sekhon had begun to rent an apartment from her.

In July 2010, a dispute arose between Patient A and Dr. Sekhon regarding damage to the apartment. Dr. Sekhon telephoned Patient A and stated, "Are you trying to make money from me? You are no longer my patient." He placed this call while at a party, and several other people were present to hear his statement. In doing so, Dr. Sekhon breached Patient A's confidentiality. After the call, Dr. Sekhon told the other party attendees that he had been speaking to Patient A, naming her, and announcing that she was no longer his patient.

This telephone call terminated the doctor-patient relationship. In so doing, Dr. Sekhon failed to ensure that Patient A had access to the results of tests which he had ordered, failed to provide her with a reasonable opportunity to arrange care elsewhere, failed to terminate the relationship in writing, and failed to document the termination of the relationship in his patient chart. Dr. Sekhon's entries in Patient A's chart were also illegible.

A medical expert retained by the College found that Dr. Sekhon exhibited significant deficits of knowledge, skill and judgment in his care of Patient A. In addition, Dr. Sekhon fell below the standard of practice of the profession in the way in which he terminated his treating relationship with Patient A.

Dr. Sekhon failed to maintain the standard of practice of the profession and was incompetent in his care of Patient A, and engaged in disgraceful, dishonourable or unprofessional conduct with respect to the manner in which he ended the physician-patient relationship and in breaching her confidentiality by doing so in front of other people.

Patient B

Patient B attended a walk-in clinic where Dr. Sekhon worked in 2013 regarding a painful cyst on her labia. Dr. Sekhon indicated that he would freeze the area and incise the cyst. Patient B was visibly apprehensive and in pain before the procedure, and also found the procedure itself extremely painful. She returned twice over the next four days to Dr. Sekhon's office with a painful abscess, before she attended the hospital, where the abscess was incised and drained under conscious I.V. sedation.

At Patient B's visits to Dr. Sekhon's office regarding her cyst, Dr. Sekhon communicated with her impatiently, failing to listen to and appropriately address her concerns about the pain she was experiencing, or to appropriately explain her options.

A medical expert retained by the College found that Dr. Sekhon showed a lack of judgment in managing Patient B's care, by continuing to treat her when she complained of pain during the procedure instead of referring her to the hospital, and by failing to refer her to a specialist when she returned complaining of more pain.

Dr. Sekhon failed to maintain the standard of practice of the profession and was incompetent in his care of Patient B, and engaged in disgraceful, dishonourable or unprofessional conduct in his communications with her.

Patient C

Patient C was Dr. Sekhon's patient between 2009 and 2012. Patient C's wife complained to the College regarding Dr. Sekhon's treatment of her husband, expressing concern that Dr. Sekhon did not examine Patient C adequately or arrange for appropriate follow-up at his last appointment. The day after the appointment in question, Patient C was discovered unresponsive and sent to the hospital, where he subsequently died.

A medical expert retained by the College found that Dr. Sekhon fell below the standard of practice of the profession in his care of Patient C in respect of medical record-keeping. In particular, Dr. Sekhon's documentation was very brief with minimal amplification of symptoms or documentation of physical findings. A detailed management plan tended not to be provided or this complex, multi-comorbidity patient. As Patient C's wife advised, Dr. Sekhon provided a sample of Avamys to Patient C at his last appointment; however, Dr. Sekhon failed to document doing so in the patient chart.

Dr. Sekhon failed to meet the standard of practice of the profession and was incompetent in his care of Patient C.

Registrar's Investigation into Practice

Further to an investigation into Dr. Sekhon's practice, the College retained a medical expert to review 25 charts.

Dr. Sekhon failed to maintain the standard of practice and was incompetent in his care of several patients. Areas of concern were identified as follows:

- chronic disease management, such as diabetes, as adequate follow-up of these patients was not documented;
- follow-up for individuals using hormone replacement therapy or the provision of Well Woman care was not documented;
- discussion of the risks and benefits prior to prescribing of medications was often not documented;
- at times appropriate follow-up after the initiation of new medications was not documented;

- management of infants and well babies was lacking, as the Rourke baby record was not used and there was inadequate discussion or management of areas of importance to well babies aside from physical findings;
- there were often examples of individuals receiving narcotics without adequate discussion or risk review before their initiation, and drug contracts and opioid risk tools were not used from the beginning;
- there was no use of random urine drug screening or other attempts to monitor appropriateness of using narcotic substances that were prescribed; and
- medical record-keeping was substandard.

Patient D

Patient D met Dr. Sekhon through a friend. Patient D socialized with Dr. Sekhon and witnessed Dr. Sekhon taking cocaine. Dr. Sekhon then began treating Patient D as a patient, while also continuing to socialize with her and then to date her, as described below.

Dr. Sekhon billed the Ontario Health Insurance Plan for treating Patient D fourteen times between 2008 and 2009. He noted prescribing Percocet to her in ten of his notes.

During the time that Dr. Sekhon was treating Patient D, she and Dr. Sekhon began dating on a frequent basis. In Dr. Sekhon's company, Patient D began to take drugs and became addicted to narcotics. After they had gone on a number of dates, Dr. Sekhon told Patient D that she could not be his patient if they were going to date. While treating her as a patient and dating her, Dr. Sekhon told Patient D that if she had sex with him, he would give her drugs.

In 2009 after the last documented care in the patient record, Dr. Sekhon referred Patient D to another physician who became her family doctor. A few weeks later, Dr. Sekhon and Patient D began a sexual relationship. Subsequently, they began living together. They lived together for approximately two years. For approximately two months, Patient D also worked in the office of his medical practice.

After Patient D began her sexual relationship with Dr. Sekhon, he prescribed for her occasionally. Once they began a sexual relationship, Dr. Sekhon also gave Patient D drugs, including narcotics. Dr. Sekhon did not prescribe these drugs to Patient D, but instead supplied them to her in amounts of his choosing. Dr. Sekhon wrote prescriptions to other individuals, including Patient D's mother and sister, then paid for the prescriptions and took the medications back for his own use. His use of the drugs included taking the drugs himself, supplying them to Patient D, and both giving and selling them to others.

After they began their sexual relationship but before they moved in together, Patient D was together in a hotel with Dr. Sekhon when she overdosed on Percocets that he had given her. Dr. Sekhon took Patient D to the hospital at her request. At the hospital,

Patient D followed Dr. Sekhon's direction to lie about what had happened, telling nurses that she had taken an unknown pill at a party, because Dr. Sekhon did not want the hospital to know that she had taken and been harmed by drugs that he had given her. On one occasion during the course of their relationship, Dr. Sekhon tied Patient D to her bed, injected her with Demerol, and had sexual intercourse with her against her will while she remained tied to the bed.

On one occasion after Patient D broke up with Dr. Sekhon, when visiting her he took two Fentanyl patches that had been prescribed to her and applied them to himself instead. Patient D provided College investigators with a photograph of Dr. Sekhon, sleeping nude in her bed with these Fentanyl patches on his buttocks.

Dr. Sekhon engaged in sexual abuse of and disgraceful, dishonourable or unprofessional conduct in relation to Patient D. Further, Dr. Sekhon engaged in disgraceful, dishonourable or unprofessional conduct in writing prescriptions to others and then taking back the medications so prescribed for his own use, including taking them himself, selling them, and giving them to Patient D.

Patient E

Patient E worked for Dr. Sekhon as his office manager from 2014 to 2015. Dr. Sekhon also had a doctor-patient relationship with Patient E from 2014 to 2015.

About six months after Patient E began working for Dr. Sekhon, he began to make sexualized comments towards her at the office. For example, he would make comments about her body, such as "Your ass looks great today," "Big breasts, love to hold them," "new jeans – your ass looks good in them," "You are going to get spanked," and "Does Dr. Sekhon need to spank you?" Dr. Sekhon asked Patient E to come to his house for a sexual encounter, but she did not go.

Dr. Sekhon also sent Patient E sexualized texts and emails. Patient E received sexualized emails as often as two to three times a day. For example, Dr. Sekhon sent Patient E pictures of women touching themselves sexually and requested that she send him photographs of herself naked.

Patient E asked Dr. Sekhon to stop the behaviour described above, but it continued until, as a result, she quit her job at his office in 2015.

After Patient E quit her job as a result of his sexual harassment, Dr. Sekhon made false allegations against her. Dr. Sekhon filed a police report that accused Patient E of defrauding him by issuing over $90,000 in cheques to herself using a stamp in place of his signature. Dr. Sekhon also falsely accused Patient E of fraud in respect of almost $15,000 he owed to a newspaper for advertising services respecting his medical practice. Dr. Sekhon had himself contracted to pay for the advertising services in question, but failed to do so. Dr. Sekhon maintained his false allegations against Patient E in a police interview, but police declined to press charges against her.

Dr. Sekhon engaged in sexual abuse of Patient E, and in disgraceful, dishonourable or unprofessional conduct towards Patient in respect of his sexual harassment of her and his false accusations towards her, as well as in disgraceful, dishonourable or unprofessional conduct in failing to pay monies owing to the newspaper for advertising services respecting his medical practice.

Patient F

Patient F was employed by Dr. Sekhon in his office from approximately 2014 to 2015. Patient F also had a doctor-patient relationship with Dr. Sekhon beginning in 2014 and continuing to 2015.

On occasion Dr. Sekhon asked Patient F to attend in an examination room to accompany him when he was doing a Pap smear on a female patient. In doing so, he used inappropriate, sexualized language that made Patient F uncomfortable, by asking her to "come and look at pussy" with him. Patient F also witnessed Dr. Sekhon's sexualized comments and was uncomfortable with them. Dr. Sekhon sent Patient F an inappropriate sexualized text message, which contained a photograph of a naked man with his penis erect. Patient F expressed her disgust at this behaviour to Dr. Sekhon.

Dr. Sekhon engaged in sexual abuse of and disgraceful, dishonourable or unprofessional conduct towards Patient F.

Ms. G

Ms. G was employed by Dr. Sekhon for approximately three weeks on a part-time basis after school in 2015. She was a Grade 11 student.

Dr. Sekhon made inappropriate and sexualized comments to Ms. G. In particular:

- Dr. Sekhon asked Ms. G if she would dance for him if he put on music;
- Once or twice a day, Dr. Sekhon went to have a nap on an examination table in his office. He would lie down and ask Ms. G to "tuck him in," which entailed Ms. G fetching a blanket and tucking it all around him. Ms. G complied with his requests but was uncomfortable; and
- Dr. Sekhon referred to Ms. G around the office to other employees as "the bitch."

Ms. G expressed her concerns with Dr. Sekhon's behaviour to his office manager, who was Patient E. Afterwards, Dr. Sekhon fired Ms. G. Dr. Sekhon engaged in disgraceful, dishonourable or unprofessional conduct towards Ms. G.

Patient H

Patient H was Dr. Sekhon's patient from 2008 until 2011. To Dr. Sekhon's knowledge, Patient H was addicted to narcotics, as she disclosed this to him. Patient H began

attending Dr. Sekhon's office as a patient because she had heard from a friend that he would prescribe narcotics to her, which he did.

On one occasion during a medical appointment Dr. Sekhon inserted an anal speculum into Patient H's rectum in a manner that felt inappropriate to her and unlike any other examination involving a speculum she had previously experienced. While there was a clinical reason for the examination, Dr. Sekhon sexualized the examination for his own purposes, leaning into her during the process. Afterwards, Dr. Sekhon told her that she was a beautiful person who could get any man that she wanted. Patient H observed that Dr. Sekhon had an erection while he spoke.

On other occasions, Dr. Sekhon made similar comments to Patient H about her appearance and her ability to "get any guy." Dr. Sekhon would also call Patient H late at night, and she believed that he was grooming her for sexual overtures.

Dr. Sekhon purported to perform two breast examinations on Patient H, but in fact used those occasions to fondle her breasts. He touched her breasts lightly with half of his hand and squeezed her nipples.

Dr. Sekhon engaged in sexual abuse of Patient H and disgraceful, dishonourable or unprofessional conduct towards her.

Ms. I

Ms. I began an occasional sexual relationship with Dr. Sekhon in approximately 2001 or 2002, continuing until approximately 2010. Dr. Sekhon would sometimes pay her money for her sexual services.

Dr. Sekhon supplied Ms. I with Oxycontin by writing prescriptions for other individuals, then obtaining the drugs from them after they filled the prescriptions, in order to give them to Ms. I. Ms. I sometimes waited in Dr. Sekhon's car while he waited for the other individual to fill a prescription for Oxycontin, then he would give her the drugs, either in a bottle with the prescription label peeled off or in a baggie. On one occasion, Dr. Sekhon contacted Ms. I to inquire whether she was willing to take a prescription for narcotics from him, sell some of the narcotics, and bring the money back to him, but Ms. I declined.

Dr. Sekhon engaged in disgraceful, dishonourable or unprofessional conduct in relation Ms. I.

Patient J

Patient J was Dr. Sekhon's patient between approximately early 2010 and the end of 2012. She was experiencing chronic pain, and Dr. Sekhon prescribed her narcotics, to which she became addicted.

Patient J told Dr. Sekhon that she had back pain. Dr. Sekhon directed her to lower her pants to her thighs while standing, exposing her buttocks. He did not offer her a drape or covering. Dr. Sekhon would direct her to turn around with her back to him. He would then fondle and touch the cheeks of Patient D's exposed buttocks for his own sexual purposes, while purporting to conduct a lower back examination. This occurred during several medical appointments. Patient J felt that if she did not do what Dr. Sekhon wanted, she would not obtain her prescriptions.

Dr. Sekhon engaged in sexual abuse of Patient J and in disgraceful, dishonourable or unprofessional conduct in relation to her.

Patient K

Patient K was Dr. Sekhon's patient from 2006 through 2013. During this time, Patient K became addicted to Oxycontin.

Patient K developed what he regarded as a friendship with Dr. Sekhon. Dr. Sekhon suggested to Patient K that Patient K seek to become a medical marijuana patient and sell off some of the marijuana, in order to split the proceeds with Dr. Sekhon.

For a period of approximately ten months, Patient K did not attend at Dr. Sekhon's office for medical appointments. Instead, another person attended and picked up his narcotics prescriptions from Dr. Sekhon.

Dr. Sekhon engaged in disgraceful, dishonourable or unprofessional conduct in relation to Patient K.

Narcotics Prescribing Practices

A medical expert retained by the College opined that Dr. Sekhon fell below the standard of practice of the profession in his care of twelve patients whose charts were reviewed, including among others Patient H, Patient J, and Patient D's mother and sister and noted the following concerns:

(a) Dr. Sekhon rapidly progressed to narcotic prescription without adequate discussion of opioid risk in multiple cases, in some cases prescribing narcotics on the first visit without such a discussion and/or without a physical examination;
(b) Dr. Sekhon discontinued prescribing narcotics to a patient abruptly without adequate discussion, education, and management of the circumstances;
(c) Pharmacy profiles of narcotics prescribed to some patients revealed prescriptions for which there was no record of medical appointments in the patient chart or any noted rationale;
(d) In multiple cases a wide array of narcotics was used for an extended period of time, but it was difficult to understand the logic of the medication and the alterations that were made;

(e) Dr. Sekhon's documentation was "vague and minimalist," and in multiple charts there was a lack of opioid risk tools, drug contracts, or other identifiable monitoring;
(f) Dr. Sekhon continued to prescribe narcotics where there were addiction issues; and
(g) Dr. Sekhon failed to note any discussion with a patient about three episodes of apparently lost or stolen prescriptions for narcotics, potential seizures, and potential withdrawal symptoms after she ceased using a benzodiazepine. He showed poor judgment in continuing to prescribe her Oxycontin.

Dr. Sekhon failed to maintain the standard of practice and was incompetent in his care of the twelve patients referred to above.

Obstruction of the College Investigations and Prosecution

Dr. Sekhon has consistently sought to conceal his misconduct from the College, including by obstructing and interfering with the College's investigations and prosecution of him. During his relationship with Patient D and after she broke up with him, Dr. Sekhon threatened Patient D. He threatened to hurt her or her family if she told the College of his misconduct, or to have her 'red flagged' as a drug addict with hospitals.

When College investigators notified Dr. Sekhon of the College's investigation regarding Patient D in October 2011, Dr. Sekhon claimed that he had no records of her, and had only treated her briefly at a walk-in clinic long ago. This was not true.

College investigators initially interviewed Patient D in September 2011. They also interviewed her mother, who advised that Dr. Sekhon had visited her house the day before the investigator and told her not to speak to the investigator. A month later, in October 2011, Patient D advised a College investigator that Dr. Sekhon had given her mother letters for Patient D to sign in return for money, saying that she was not in fact Dr. Sekhon's patient. Patient D read the text of the letters over the telephone to the investigator, and said she would send them in for the investigator to see. She also advised that after he learned of the investigation Dr. Sekhon had visited her mother again and threatened to "bring down" Patient D. Patient D was frightened and no longer wanted to cooperate with the investigation.

In May 2012, the College received a letter from a lawyer who said he had been retained by Patient D, stating that her allegations were false and that she had made them only as a result of harassment by the College investigator. In October 2012, the College received a handwritten letter from Patient D stating among other things that the College investigator was "mean and abusive," and that "none of the stuff he made me say and read were true. Raj Sekhon never raped me or even gave me drugs!! Raj Sekhon was also never my doctor." The contents of these letters were false. Dr. Sekhon visited the lawyer with Patient D to ensure that she retracted the allegations against him in May 2012, and paid for the lawyer's services. Dr. Sekhon wrote the text of the October 2012 letter himself, and had Patient D write it out and send it to the College.

The concerns regarding Dr. Sekhon's conduct towards Patient D initially came to the College's attention by way of a mandatory report of information regarding sexual abuse from another physician of Patient D, Dr. Z. In May 2013, Patient D filed a complaint with the College against Dr. Z, alleging that Dr. Z had sexually abused her, that Dr. Z had made a false report regarding Dr. Sekhon, that Dr. Z had disclosed her medical information without consent, and that Dr. Z had given her narcotics inappropriately. This complaint was in fact written by Dr. Sekhon, who directed Patient D to send it to the College through a lawyer that they visited together. Dr. Sekhon sought to retaliate against Dr. Z for having reported him and to discredit the information that Patient D had provided to the College about his own misconduct.

Patient D agreed to provide the above-noted false information to the College in part because she cared about Dr. Sekhon, but also because she was afraid of him as a result of threats he had made. Finally, Dr. Sekhon also gave Patient D money in return for sending the letters to the College.

Patient D's mother also sent a letter to the College in July 2012, complaining about the conduct of the College investigator. This letter was also false, and was given to her by Dr. Sekhon to sign. Dr. Sekhon gave her money in return. After allegations regarding Dr. Sekhon's conduct towards Patient D were referred to discipline in June 2015, Dr. Sekhon began calling and texting Patient D very frequently, telling her that he loved her and asking her to sign more papers stating that she had lied. At the same time, he also threatened her, telling her that no one would care if she died. Dr. Sekhon was making these efforts in order to obstruct the College prosecution.

Patient D's mother contacted the College in August 2015 because she was concerned. As a result, the College investigator learned from Patient D and her family that Patient D's earlier retraction of her allegations had been as a result of Dr. Sekhon's efforts to obstruct the investigation. Patient D and her family also disclosed for the first time that Dr. Sekhon had prescribed to Patient D's mother and sister only in order to take back the medications for his own use, as described above. Patient D's mother provided prescription receipts for eight prescriptions for Fentanyl in her name that Dr. Sekhon took from her, as well as two prescriptions for injectable narcotics. The investigator provided advice to the family to contact the police for help in the event of any further contact from Dr. Sekhon. The College warned Dr. Sekhon through his lawyer to cease his unwelcome and inappropriate contact with Patient D.

In addition to the steps described above that Dr. Sekhon took regarding Patient D and her family, Dr. Sekhon took other steps to obstruct and interfere with the College's investigations into his misconduct:

(a) College investigators interviewed Patient D's friend and roommate, Mr. L, during their investigation. Mr. L provided information regarding Patient D's relationship with Dr. Sekhon and Dr. Sekhon's prescribing practices. Afterwards, Mr. L signed a letter recanting what he had told the College. The letter was written by Dr.

Sekhon. Mr. L signed the letter at Patient D's request, because he wanted Dr. Sekhon to stop harassing her.

(b) Dr. Sekhon had Ms. I send a letter to the College in November 2013, retracting the information she had provided to the College and accusing the College investigator of pushing her to make false statements.

(c) Dr. Sekhon contacted Patient K before the College investigator interviewed Patient K, and told him that he might be contacted by investigators, but not to say a "f**** word." Dr. Sekhon rehearsed with Patient K what he was to say to investigators, and promised that "if you shut your mouth I'll take care of you." As a result, when Patient K was first interviewed by the College, he was untruthful.

(d) Dr. Sekhon asked Patient D to contact Patient A and another witness in that matter in order to influence the College's investigation in that matter, but Patient D did not do so.

(e) Dr. Sekhon had been prescribing narcotics to one of Patient D's sisters, Patient M. Dr. Sekhon paid for some of the prescriptions and took them to sell, give to Patient D, or otherwise use, as described above. Patient M's boyfriend Mr. N threatened to tell on Dr. Sekhon. As a result, Dr. Sekhon paid for Mr. N to see Dr. Sekhon's lawyer, and also gave Mr. N a bottle of Oxycontin.

Dr. Sekhon engaged in disgraceful, dishonourable or unprofessional conduct in seeking to interfere with and obstruct the College's investigation and prosecution.

Disposition

On October 12, 2016, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Sekhon's certificate of registration, effective immediately;
- Dr. Sekhon reimburse the College for funding provided to those patients in respect of whom this panel has found Dr. Sekhon to have engaged in sexual abuse, under the program required under section 85.7 of the Code;
- Dr. Sekhon post an irrevocable letter of credit or other security acceptable to the College, to guarantee the payment of any amounts he may be required to reimburse under paragraph 5 of this Order, such security to be posted within thirty (30) days of the date of this Order, in the amount of $80,300.00;
- Dr. Sekhon appear before the panel to be reprimanded;
- Dr. Sekhon pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date of this Order.

6. Dr. D.A. Ruggiero

Name:	Dr. Donato Anthony Ruggiero
Practice:	Independent Practice
Practice Location:	Toronto
Hearing:	Contested
Decision/Written Decision Date:	August 23, 2016
Penalty Decision Date:	October 14, 2016
Penalty Written Decision Date:	January 16, 2017

Allegations and Findings

- Engaged in sexual impropriety with a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Ruggiero received his certificate of registration in 1973. He had a solo practice in Toronto at the relevant time.

Patient A attended Dr. Ruggiero's office for abdominal pain in or about 1986, when she was in her late teens. The Committee found that Patient A had three appointments with Dr. Ruggiero.

On Patient A's last visit with Dr. Ruggiero, she was asked to remove her clothing from the waist down and to lie on the examination table and place her feet in the stirrups.

The Committee rejected Dr. Ruggiero's evidence that he performed a pelvic examination at Patient A's last visit, and that she mistook the examination for sexual impropriety.

The Committee found that when Dr. Ruggiero asked Patient A to undress from the waist down and lie down on the examination table, it was not his intention to perform a medically-indicated pelvic examination. Rather, his true intent was to take advantage and exploit a vulnerable patient by inserting his penis into her vagina for self-gratification.

The Committee found that Dr. Ruggiero was being deceptive when he provided various explanations to College investigators, the Committee, and Patient A's mother, for why he would have performed a pelvic examination. These explanations did not have a factual basis and were merely attempts to provide a legitimate explanation for why he would have asked Patient A to undress from the waist down and lie on the examination table for a purported pelvic examination. Dr. Ruggiero spontaneously described Patient A to a College investigator as having been dressed "very, very seductively" the day of the assault, and he recalled her appearance. Dr. Ruggiero also testified that Patient A

was not a virgin when he saw her. The Committee found that Dr. Ruggiero perceived Patient A in a sexualized manner.

The Committee found that Patient A raised her head to see what was going on during the appointment, and saw Dr. Ruggiero's pants unzipped and his penis with a condom on it going in and out of her vagina, while hearing him moaning.

The Committee did not find Dr. Ruggiero to be a credible witness. There were numerous inconsistencies in his testimony. The Committee found Patient A to be a credible witness and her testimony to be reliable.

In his conduct towards Patient A, Dr. Ruggiero committed an act of professional misconduct, in that he engaged in sexual impropriety with a patient.

Disposition

On October 14, 2016, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Ruggiero's certificate of registration, effective immediately;
- Dr. Ruggiero appear before the panel to be reprimanded within sixty (60) days of this Order becoming final; and
- Dr. Ruggiero pay costs to the College in the amount of $25,000.00 within thirty (30) days of the date of this Order becoming final.

Appeal

On October 31, 2016, Dr. Ruggiero appealed the decisions on liability and penalty of the Discipline Committee to the Divisional Court of the Superior Court of Justice.

7. Dr. UVW

Name:	Dr. UVW
Practice:	Family Medicine
Practice Location:	Redacted
Hearing:	Contested
Decision / Written Decision Date:	December 1, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient – **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **not proved**

Failure to maintain standards – 3 cases

1. Dr. S. Jiaravuthisan

Name:	Dr. Somchai Jiaravuthisan
Practice:	Neurology
Practice Location:	Oshawa
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	November 7, 2016
Written Decision Date:	December 16, 2016

Allegation and Finding

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Sexual abuse of a patient - **withdrawn**

Summary

On November 7, 2016, the Discipline Committee of the College of Physicians and Surgeons of Ontario found that that Dr. Somchai Jiaravuthisan has committed an act of professional misconduct in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional and in that he has failed to maintain the standard of practice of the profession.

Dr. Jiaravuthisan, a neurologist practising in Ontario since 1982, attended medical school at Mahidol University in Thailand and worked at the Glazier Medical Centre in Oshawa.

Patient A

Patient A had a single office appointment with Dr. Jiaravuthisan in May 2009. She was referred Dr. Jiaravuthisan for pain in her hand, hyperemia in both hands, and positive Tinel's sign. When Dr. Jiaravuthisan took a history from Patient A, she experienced his questions as abrupt and his manner as directive. Dr. Jiaravuthisan commenced and documented an examination of Patient A. He examined her gait, took her vital signs, and examined her cardiovascular and respiratory systems.

Although Dr. Jiaravuthisan's examination of Patient A was medically indicated, he failed to explain the steps of his examination or to seek Patient A's informed consent to the examination which he was conducting.

As part of his physical examination, Dr. Jiaravuthisan began to palpate Patient A's abdomen while she lay on an examination table. As he did so, he moved his hands below the waist band of her trousers to the suprapubic area below her navel, again

without explanation or seeking informed consent. In doing so, Dr. Jiaravuthisan failed to show sensitivity and respect for Patient A's comfort, which was unprofessional.

Patient A was confused and upset by Dr. Jiaravuthisan's actions and did not know why he had moved his hands below the waist band of her trousers. She sat up and demanded to know what he was doing, then left the examination room and complained to his office staff about his behaviour.

Patient B

Patient B attended the single office appointment she had with Dr. Jiaravuthisan in October 2013 with a friend, who was also present in the examination room. Patient B's family physician referred her to see Dr. Jiaravuthisan because of leg pain, weakness, and tingling.

Dr. Jiaravuthisan took a history from Patient B. Dr. Jiaravuthisan also conducted and documented an examination of Patient B, including a neurological examination, motor system examination, and physical examination.

Although Dr. Jiaravuthisan's examination of Patient B was medically indicated, he failed to explain the steps of his examination or to seek Patient B's informed consent to the examination which he was conducting.

Dr. Jiaravuthisan failed to offer Patient B appropriate draping or a gown, or to wear a glove or gloves while examining her. He also displaced her clothing himself by putting his hand under her pants, by rolling up one of her pant legs himself, and by pulling her shirt.

Dr. Jiaravuthisan did not take sufficient care to maintain spatial boundaries with Patient B while examining her. While he was palpating Patient B's abdomen with one hand, without warning, Dr. Jiaravuthisan placed his other hand below her underpants on her mons pubis (external genital area) for approximately thirty seconds. Dr. Jiaravuthisan advises that any such contact would have been inadvertent, as he intended only to palpate Patient B's suprapubic area.

Dr. Jiaravuthisan then directed Patient B to roll over to examine her tailbone area where she said that she had been experiencing pain. Dr. Jiaravuthisan palpated Patient B's tailbone area underneath her clothing. In the course of doing so, he touched Patient B's buttocks in what felt to her like a squeezing motion. In examining Patient B's face, Dr. Jiaravuthisan also touched her face in a manner that felt to her like grabbing.

Because Dr. Jiaravuthisan did not show sensitivity and respect for Patient B's comfort by maintaining spatial boundaries, communicating appropriately regarding the examination, and offering draping, the appointment was very distressing to Patient B. Dr. Jiaravuthisan's conduct in this regard was unprofessional.

Afterwards, Patient B told office staff in tears that she did not like how Dr. Jiaravuthisan had touched her and did not want to return, and she expressed her concerns to her family physician.

On October 19, 2016, Dr. Jiaravuthisan entered into an undertaking with the College agreeing to resign his certificate of registration effective November 7, 2016, and not to reapply for a certificate in future.

Disposition

On November 7, 2016, in light of Dr. Jiaravuthisan's undertaking to resign his certificate of registration and not to reapply, the Discipline Committee ordered and directed that:

- Dr. Jiaravuthisan appear before the panel to be reprimanded.
- Dr. Jiaravuthisan pay to the College its costs of this proceeding in the amount of $5,000.00 within thirty (30) days from the date of this Order.

2. Dr. J.P. Lucas

Name:	Dr. Jan Pieter Lucas
Practice:	General Practice
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	October 27, 2016
Written Decision Date:	November 10, 2016

Allegation and Finding

- Failure to maintain standards of practice of the profession – **proved**
- Incompetence – **withdrawn**

Summary

On October 27, 2016, the Discipline Committee of the College of Physicians and Surgeons of Ontario found that Dr. Jan Pieter Lucas has committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession, including with respect to his infection control practices, documentation, and preoperative assessments.

Dr. Lucas, an anesthesiologist who received his certificate of independent practice in Ontario in 1965, provided anesthesiology services at Downsview Endoscopy Clinic ("DEC") in Toronto. He resigned his CPSO membership in 2013, when he was 83 years old, and has not practised medicine since.

In August 2014, the College received a letter from Toronto Public Health reporting that three patients had been infected with Hepatitis C virus after undergoing endoscopy

procedures at DEC. The letter led to the initiation of a s. 75(1)(a) investigation by the College.

Toronto Public Health Investigation

On June 6, 2013, a patient who had undergone a colonoscopy at DEC on December 7, 2011 was reported to Toronto Public Health as Hepatitis C virus positive ("Patient 1"). Toronto Public Health commenced an investigation.

By matching patient lists and records of reported Hepatitis C virus cases, Toronto Public Health determined that three other patients who had undergone endoscopic procedures at DEC on December 7, 2011 were also Hepatitis C virus positive. Two of those patients (Patient 2 and Patient 3) were reported Hepatitis C virus positive after their procedures at DEC. The other patient ("Patient 0"), who had been seen prior to Patients 1, 2, and 3, was determined to be the source of the Hepatitis C virus outbreak. Patient 0's Hepatitis C virus was genetically highly related to that of Patients 1, 2 and 3.

Dr. Lucas acted as the anesthesiologist for the procedures on each of the four patients on the date in question, December 7, 2011.

Toronto Public Health provided the College with its interim report of August 21, 2014 and final report of October 6, 2014, both of which concluded that Patients 1, 2 and 3 acquired Hepatitis C virus during their endoscopic procedures at DEC on December 7, 2011 and that Patient 0 was the source of the outbreak.

Toronto Public Health noted that Hepatitis C virus transmission has often been documented as being linked to mishandling of multi-dose injectable medications. It concluded that it is possible that either a vial of propofol anesthetic or a vial of lidocaine (used to reduce the sting of the anesthetic) became contaminated after being used on the source patient.

Dr. Lucas administered propofol anesthetic and lidocaine to all four patients during the procedures in question on December 7, 2011. Dr. Lucas acknowledged it was his practice to reuse syringes containing fentanyl between patients, only changing the needle. Toronto Public Health concluded that the contamination of fentanyl leading to transmission to all three patients did not seem likely.

College Investigation

In written responses to the College investigation, Dr. Lucas admitted that it was not his practice to swab multi-dose vials before withdrawing medication. The propofol anesthetic and lidocaine used at DEC were contained in multi-dose vials.

The College retained two experts in infection prevention and anesthesiology as Medical Inspectors to assist in its investigation.

The first medical inspector concluded that Dr. Lucas did not meet the standard of practice with respect to infection control procedures, documentation, and preoperative assessment, including:

- No documentation of pre-procedure vitals, patient weight, NPO status, airway assessment, physical examination, or post-procedure vitals or level of consciousness;
- No pre-operative blood glucose, despite the history of diabetes and oral hypoglycemic medication;
- Incomplete medication list;
- Incomplete pre-anesthetic assessment;
- Hypotension not treated on arrival and blood pressure not reassessed post-procedure to ensure it had returned to normal; and
- Re-using fentanyl syringes between patients.

Dr. Lucas displayed a lack of skill and a lack of knowledge regarding appropriate infection control practices in the setting of medication administration, including not being aware of the risks involved in reusing syringes between patients;

Dr. Lucas' clinical practice exposed his patients to harm, including by:

- providing deep sedation without an appropriate pre-procedure assessment
- reusing syringes between patients.

The first expert further opined: "It is well-established that syringes are easily contaminated especially when injecting directly into a saline lock. It is clearly below standard of care for a physician to re-use syringes or needles between patients and to be unaware of risk to patients…Theoretically, the top of the vial could become contaminated as a result of poor hand hygiene after the intravenous insertion. The medication inside could possibly become contaminated if the top of the vial was not appropriately cleaned before re-entering. There is no evidence that vials were deliberately contaminated."

The second expert concluded that Dr. Lucas did not meet the standard of practice with respect to infection control procedures. Dr. Lucas reused syringes of fentanyl between patients, only changing the needle. This posed significant risk to his patients. Further, Dr. Lucas' care displayed a lack of skill and knowledge. Dr. Lucas should have been aware of the risks of reusing a syringe of medication between patients. This deficit was significant.

Dr. Lucas has executed an undertaking never to engage in the practice of medicine again.

Disposition

In light of Dr. Lucas' undertaking never to engage in the practice of medicine again, on October 27, 2016, the Discipline Committee ordered and directed that:

- Dr. Lucas appear before the panel to be reprimanded; and
- Dr. Lucas pay to the College costs in the amount of $5,000.00 within 30 days of the date of this Order.

3. Dr. J.L. Ruggles

Name:	Dr. Janice Louise Ruggles
Practice:	Obstetrics / Gynecology
Practice Location:	Pickering
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	October 5, 2016
Written Decision Date:	December 5, 2016

Allegation and Finding

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **withdrawn**

Summary

Dr. Ruggles, an obstetrician-gynecologist, practised at a private office in Pickering and held hospital privileges at the Rouge Valley Health System in the Greater Toronto Area.

2011 College Investigation

On January 31, 2011, the College received information from a pharmacist that Dr. Ruggles had written prescriptions for large quantities of OxyContin over the past several years to a non-patient with whom Dr. Ruggles had a work-related association. The College launched a section 75(1)(a) investigation under the Health Professions Procedural Code.

Dr. Ruggles sent a response to the College investigation dated June 14, 2011, acknowledging that she had provided prescriptions to the individual ("Individual 1"), and promised to treat and/or prescribe only to those with whom she has a doctor/patient relationship and in circumstances where she has conducted a complete assessment.

The Inquiries, Complaints and Reports Committee ("the ICRC") cautioned Dr. Ruggles in writing regarding inappropriately prescribing narcotics and treating a person with whom she had a work-related association, including by prescribing narcotics to that individual. The ICRC noted that Dr. Ruggles' prescription of narcotics and other

medications to a person with whom she had a work-related association was clearly inappropriate; that this was an isolated event in Dr. Ruggles' practice; and that Dr. Ruggles admitted to the indiscretion and agreed to appropriate remediation. The ICRC also required Dr. Ruggles to complete a boundaries course and a narcotics prescribing course, which she completed in 2012.

Current College Investigation

In May 2013, another individual with whom Dr. Ruggles had a work-related association ("Individual 2") called the College to advise that Dr. Ruggles had been prescribing narcotics to that individual.

The College commenced a s. 75(1)(a) investigation and obtained pharmacy records, which demonstrated that Dr. Ruggles had written the following prescriptions for Individual 2:

July 6, 2011:	Clonazepam 5mg, 180 tablets, with 2 repeats
Nov 3, 2011:	Azithromycin (Zithromax) 500 mg po OD, then 250mg po 4 days
July 25, 2012:	Macrobid, 100mg for 7 days Naproxen 500mg po tid, 80 tablets, with 1 repeat; Oxy IR 10mg, 60 tablets, with 1 repeat
Nov 20, 2012:	Oxy IR 10mg, 60 tablets, with 1 repeat; Naproxen 500mg po tid no substitution, 80 tablets, 1 repeat
Dec 10, 2012:	Tamiflu, 75mg, 5 day supply

In her response to this investigation, Dr. Ruggles admitted to treating Individual 2 and to providing these prescriptions to Individual 2 during their work-related association.

Dr. Ruggles wrote the first prescription for Individual 2 within weeks of her June 14, 2011 response to the College's previous investigation. Dr. Ruggles wrote the additional prescriptions for Individual 2 both before and after she completed the boundaries and narcotics prescribing courses required by the College, and both before and after she received the ICRC decision cautioning her for this behaviour.

Expert Report

The College retained an expert to review Dr. Ruggles' care of patients in her office practice, who stated that the main issues of concern, ordering much larger amounts of narcotics than commonly prescribed, in particular, Oxycodone, Clonazepam, and Ativan, were found in three of the 24 charts reviewed and the related prescription analysis.

One of these 3 charts was that of Individual 2. The care Dr. Ruggles provided to Individual 2 did not meet the standard of practice. The expert noted: "A large amount of narcotics and sedatives were prescribed… She did not show good judgment and her management of this patient fell below the standard of practice. The same can be said

about the Doctor's failure to recognize the conflict of interest and potential harm created by continuing to keep [Individual 2] as a patient …Dr. Ruggles also failed to maintain proper boundaries in this relationship."

With respect to a second patient, the expert stated: "I find it concerning that the patient was seen only twice within 1 month and had 2 prescriptions for a total of 300 Oxy RI [sic] tabs, 200 Ativan tabs, and 180 Rivotril tabs. Based on the above information, I feel that in this case the standard of care was not met. The Physician was not likely prescribing within her scope of practice and did not show good judgement."

With respect to a third patient, the expert noted that the patient was given a prescription of 200 Percocets in March 2011, and 60 Percocets and 60 Toradol in June 2011. 30 more Percocets were prescribed in November 2011. The expert concluded that this was overly generous prescribing and that Dr. Ruggles did not meet the standard of care as she prescribed an excessive amount of narcotics, putting the patient at risk.

The expert opined that Dr. Ruggles demonstrated a lack of knowledge and judgment in respect of these three cases, and that, in respect of the first and second cases, Dr. Ruggles was not likely prescribing within her scope of practice.

With respect to the 21 other patients reviewed, the expert opined that the care provided by Dr. Ruggles met the standard of practice.

On September 29, 2014, in response to this investigation and the expert report, Dr. Ruggles volunteered to cease all prescriptions of narcotics other than to patients seen in her hospital practice. Dr. Ruggles also offered to undertake to no longer treat or have any clinical dealings with those people with whom she had work-related associations.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Ruggles' certificate of registration for a two (2) month period, to commence at 12:01 a.m. on October 13, 2016 and concluding at 12:01 a.m. on December 13, 2016.
- The Registrar impose the following terms, conditions and limitations on Dr. Ruggles' certificate of registration:
  - Dr. Ruggles shall not issue new prescriptions or renew existing prescriptions for any of the following substances:

    (a) Narcotic Drugs (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

    (b) Narcotic Preparations (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

    (c) Controlled Drugs (from Part G of the *Food and Drug Regulations* under the *Food and Drugs Act*, S.C., 1985, c. F-27);

(d) Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act.*, S.C., 1996, c. 19); or (A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule "**A**"; and the current regulatory lists are attached hereto as Schedule "**B**"); and

(e) All other Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 as noted in Schedule "**C**"); and as amended from time to time.

- Dr. Ruggles will return any supplies of the substances referred to in paragraph (1) above that are presently in her possession, in any place, to a pharmacy in a safe and secure manner, as stipulated in the College's Policy Number 8-12, "Prescribing Drugs."
- Notwithstanding paragraph 5.(1):

  (a) Dr. Ruggles may prescribe the above-noted substances to her in-patients only, during the course of their in-patient stay through the hospital pharmacy; and

  (b) Dr. Ruggles may issue prescriptions to patients she treats in the emergency department while on call, hospital outpatients or hospital inpatients on discharge of only:

  (i) Tylenol #3 (to a maximum of 10 tablets, with no repeats); or

  (ii) OxyIR 10 mg (to a maximum of 10 tablets, with no repeats).

  And said prescriptions may only be issued to emergency department patients, hospital outpatients or to hospital inpatients on discharge in relation to the following procedures:

  (i) Caesarean Sections;

  (ii) Complex Vaginal Deliveries;

  (iii) Laparoscopic Surgery;

  (iv) Open Abdominal Surgery; or

  (v) Perineal/Vaginal procedures.
- Dr. Ruggles shall post a sign in the waiting room(s) of her office, in a clearly visible and secure location, in the form set out at Schedule "**D**". For further clarity, this sign shall state as follows: "Dr. Ruggles shall not prescribe Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, or any other Monitored Drugs. Dr. Ruggles shall not provide any medical advice, recommendations, consultations, treatment or prescriptions to any of her employees. Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca".
- Dr. Ruggles shall post a certified translation in any language in which she provides services, of the sign described in paragraph 5.(4) above, in the waiting room(s) of her office.

- Dr. Ruggles shall provide the certified translation(s) described in paragraph 5.(5), to the College within thirty (30) days of this Order.
- Should Dr. Ruggles elect to provide services in any other language(s), she must notify the College prior to providing any such services.
- Dr. Ruggles shall provide to the College the certified translation(s) described in paragraph 5.(5) prior to beginning to provide services in the language(s) described in paragraph 5.(7).
- In the event that Dr. Ruggles writes a prescription pursuant to paragraph 5.(3), she shall record this prescription and other specified information in a prescription log in the form attached as Schedule "**E**", which shall be made available to the College at the College's request. Dr. Ruggles shall also append to the prescription log a copy of each prescription she issues under paragraph 5.(3).
- Dr. Ruggles shall provide a document in the form set out at Schedule "**F**" to each patient to whom she prescribed in accordance with paragraph 5.(3). The patient shall initial the document, and Dr. Ruggles shall append a copy of the initialed document to the log referred to in paragraph 5.(9).
- Dr. Ruggles will not treat any office or hospital employees or family members in any manner whatsoever, except in an emergency situation. This includes, but is not limited to, providing advice, consultations, treatment, prescriptions or treatment recommendations.
- At her own expense, Dr. Ruggles shall participate in and successfully complete, within 6 months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Ruggles.
- Dr. Ruggles shall undergo a reassessment of her practice approximately twelve (12) months from the date of this Order.
- Dr. Ruggles must inform the College of each and every location that she practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within fifteen (15) days of commencing practice at that location.
- Dr. Ruggles shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the terms of this Order.
- Dr. Ruggles shall co-operate with unannounced inspections of her Practice Location(s) and patient charts by the College and to any other activity the College deems necessary in order to monitor her compliance with the terms of this Order.
- Dr. Ruggles shall provide her irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the Narcotics Safety and Awareness Act, 2010 and any person or institution that may have relevant information, in order for the College to monitor her compliance with the terms of this Order.
- Dr. Ruggles acknowledges that the College may provide this Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where she practices or has privileges ("Chief(s) of Staff"), or other person or individual as necessary for the implementation of this Order and shall consent to the College

providing to said Chief(s) of Staff, person or organization with any information the College has that led to this Order and/or any information arising from the monitoring of her compliance with this Order.
- Dr. Ruggles appear before the panel to be reprimanded.

Guilty of Offence – 3 cases

1. Dr. W.T. Fung

Name:	Dr. Wing-Tai Fung
Practice:	Independent Practice
Practice Location:	No practice address
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	November 29, 2016
Written Decision Date:	December 21, 2016

Allegation and Finding

- Found guilty of an offence that is relevant to his suitability to practise – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

On November 29, 2016, the Discipline Committee of the College of Physicians and Surgeons of Ontario found that Dr. Wing-Tai Fung committed an act of professional misconduct in that he has been found guilty of an offence that is relevant to his suitability to practise and in that the governing body of a health profession in a jurisdiction other than Ontario has found that he committed an act of professional misconduct that would, in the opinion of the panel, be an act of misconduct as defined in the regulations.

Dr. Fung, a family physician, practised in Iowa from 1992 to 2008. Following his retirement from his Iowa practice in 2008, he returned to Ontario where he worked until 2014.

On March 27, 2015, Dr. Fung pled guilty in the District Court of Iowa in and for Shelby County to the charge of Assault with Intent to Commit Sexual Abuse and Indecent Contact with a Child. On that day, he received a two year suspended sentence, was ordered to register as a sex offender, to immediately surrender his license to practise medicine, and to submit to DNA profiling. Dr. Fung was also ordered to enter into a plan of restitution for the payment of all court costs, fines, and victim restitution.

The factual basis of the plea and sentence was an admission by Dr. Fung that he touched a ten-year-old patient on her inner thigh, during a medical appointment in

January 1999, with the purpose of arousing himself. Dr. Fung was 66 years old at the time of the offence.

The Iowa State Board of Medicine took action on the basis of the criminal finding. Dr. Fung agreed to the voluntary surrender of his licence. The Board delivered a citation and warning and imposed a $10,000.00 civil penalty on Dr. Fung.

Disposition

On November 29, 2016, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Fung's certificate of registration, effective immediately.
- Dr. Fung appear before the panel to be reprimanded.
- Dr. Fung pay costs to the College in the amount of $5,000.00 within thirty (30) days from the date of this Order.

2. Dr. P. Gill

Name:	Dr. Paramjit Gill
Practice:	Independent Practice
Practice Location:	Brampton
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	November 2, 2016
Written Decision Date:	December 16, 2016

Allegations and Findings

- Found guilty of an offence relevant to his suitability to practice - **proved**
- Disgraceful, dishonourable or unprofessional conduct - **proved**
- Failed to maintain the standard of practice of the profession - **withdrawn**
- Contravened a term, condition or limitation on his certificate of registration – **proved**

Summary

On November 2, 2016, the Discipline Committee found that Dr. Paramjit Gill committed an act of professional misconduct in that: he engaged in an act or omission relevant to the practise of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; he has been found guilty of an offence relevant to his suitability to practice; and, he contravened a term, condition or limitation on his certificate of registration.

Dr. Paramjit Gill, an internist, practised medicine at the Brampton Civic Hospital, William Osler Health Centre, in the Intensive Care Unit.

From about 1998 to 2006, Dr. Gill experienced alcohol addiction. In July 2006 he was admitted into the residential program at a facility dedicated to treating mental health and

addiction issues. Upon completing that program, Dr. Gill entered into a contract with the Physicians Health Program, a program administered through the Ontario Medical Association, for a five-year period ending in August 2011.

As a result of a relapse into addiction, Dr. Gill engaged in a variety of misconduct in order to maintain a supply of narcotic opioids, including Percocet, Oxycocet, Oxycodone, Lorazepam and Endocet. Dr. Gill used narcotics that had been prescribed by other physicians for Dr. Gill's close family members. He also prescribed narcotics himself, ostensibly for others, including his close family members, but these narcotics were for his own consumption. He solicited prescriptions for narcotics from colleagues. Dr. Gill also forged other physicians' signatures and prescription pads in order to obtain narcotics for himself. Ultimately, as a result of his conduct, Dr. Gill was referred to discipline by the College and also faced multiple criminal charges.

Chronology

The College commenced an investigation after hearing about concerns about Dr. Gill's prescribing practice. On October 20, 2014, the College conducted an unannounced visit to Dr. Gill's home. Dr. Gill advised the College he was on leave from the William Osler Health Centre, which was subsequently confirmed by the hospital.

The College initiated a preliminary Health Inquiry based on the concerns received from a pharmacist and information from the Ministry of Health and Long-Term Care that Dr. Gill was receiving opioid prescriptions from a number of physicians.

Dr. Gill failed to attend assessments, including an addiction assessment, ordered by the College's Inquiries Complaints and Reports Committee (ICRC). He also failed to provide signed consents to the College for access to personal health information. As a result of both of these failures, his certificate of registration was suspended on December 23, 2014.

On April 1, 2015, Dr. Gill entered into a five-year monitoring contract with the Physician Health Program and subsequently entered into an undertaking with the College dated May 14, 2015. The suspension of Dr. Gill's certificate of registration was lifted on June 12, 2015.

On April 29, 2016, following referral to discipline, Dr. Gill entered into a further undertaking with the College resigning his prescribing privileges except for issuing doctors' orders for hospital inpatients that may be dispensed only by a hospital dispensary.

To date, Dr. Gill has complied with the terms of the undertakings provided to the College and has complied with the terms set out in the PHP contract.

The College Investigation – disgraceful, dishonourable or unprofessional conduct

In November 2013, a pharmacist reported to the College that, since at least 2009, Dr. Gill had been picking up prescriptions for Percocet in the name of a close family member and he was also the prescribing physician.

The College obtained information regarding the different means used by Dr. Gill to obtain narcotic opioids for his personal consumption: Dr. Gill wrote and filled prescriptions for narcotic opioids in the names of close family members on numerous occasions between 2009 and 2015. He also wrote and filled prescriptions for narcotic opioids in his own name and in two other individuals' names between 2011 and 2014. These prescriptions were obtained from multiple pharmacies, and no OHIP billings were associated with the prescriptions. Most if not all of these narcotic opioids were for Dr. Gill's own use.

Dr. Gill also forged prescriptions in three other physicians' names, falsifying their signatures and the prescription itself, as well as using the physicians' College registration numbers. The prescriptions were written in the names of Dr. Gill's close family members and another individual. Dr. Gill filled the prescriptions and personally used these drugs.

Dr. Gill also sought out prescriptions for narcotics from his colleagues at the hospital, which was how the hospital learned that Dr. Gill was experiencing a narcotic addiction.

Writing Prescriptions Post-suspension

Following the suspension of his certificate of registration on December 22, 2014, Dr. Gill continued to prescribe himself narcotics and also wrote prescriptions for opioids in the names of close family members until at least January 27, 2015.

Criminal Charges

On January 30, 2015, the Peel Regional Police charged Dr. Gill with 52 counts of fraud under $5,000.00 and 18 counts of uttering a forged document under the Criminal Code of Canada.

On September 22, 2016, Dr. Gill was found guilty in the Ontario Court of Justice of one count of fraud and one count of uttering a forged document, following his guilty plea. Sentencing in the Ontario Court of Justice has been put over to January 19, 2017.

Disposition

On November 2, 2016, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Gill's Certificate of Registration for a five (5) month period effective immediately
- The Registrar impose the following terms, conditions and limitations on Dr. Gill's certificate of registration:

Prescribing Privileges

(a) Dr. Gill shall not issue new prescriptions or renew existing prescriptions, except as specifically set out in paragraph 5(a) below for any of the following substances:
   (i) Narcotic Drugs (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19);
   (ii) Narcotic Preparations (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19);
   (iii) Controlled Drugs (from Part G of the Food and Drug Regulations under the Food and Drugs Act, S.C., 1985, c. F-27);
   (iv) Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the Controlled Drugs and Substances Act., S.C., 1996, c. 19), as amended from time to time; (A current summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule “A”; and the current regulatory lists are attached hereto as Schedule “B”); and
   (v) All other Monitored Drugs (as defined under the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22 as noted in Schedule “C”); as amended from time to time.

(b) Dr. Gill will return any supplies of the substances referred to in paragraph 3(a) above that are presently in his possession, in any place, to a pharmacy in a safe and secure manner, as stipulated in the College's Policy Number 8-12, "Prescribing Drugs."

(c) Notwithstanding paragraph 3(a): Dr. Gill may prescribe the above-noted substances to his in-patients, only during the course of their in-patient stay and only through the hospital pharmacy.

(d) Upon request of the College, Dr. Gill will provide a Prescribing Resignation Letter to Health Canada consistent with this Order.

Posting a Sign

(e) Dr. Gill shall post a sign in the waiting room(s) of any practice location, except hospitals, in a clearly visible and secure location, in the form set out at Schedule “D”. For further clarity, this sign shall state as follows:

IMPORTANT NOTICE

Dr. Gill must not prescribe any of the following:
- Narcotic Drugs
- Narcotic Preparations
- Controlled Drugs
- Benzodiazepines and Other Targeted Substances
- All other Monitored Drugs

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

(f) Dr. Gill shall post a certified translation in any language in which he provides services, of the sign described in paragraph 3(e) above, in the waiting room(s) of his office.
(g) Dr. Gill shall provide the certified translation(s) described in paragraph 3(f), to the College within thirty (30) days of this Order.
(h) Should Dr. Gill elect to provide services in any other language(s), he must notify the College prior to providing any such services.
(i) Dr. Gill shall provide to the College the certified translation(s) described in paragraph 3(g) prior to beginning to provide services in the language(s) described in paragraph 3(h).
(j) Dr. Gill shall be subject to an assessment of his practice, within two (2) months of his return to practice, by an assessor acceptable to the College and at Dr. Gill's expense. The assessor shall select and review twenty five (25) patient charts or the patient charts for the total number of patients seen by Dr. Gill in the two (2) month period if less than twenty five (25). The assessor shall provide a report to the College following the assessment and Dr. Gill shall abide by the recommendations of the assessor.

Compliance

(k) Dr. Gill must inform the College of each and every location that he practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within fifteen (15) days of commencing practice at that location.
(l) Dr. Gill shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the terms of this Order.
(m) Dr. Gill shall provide his irrevocable consent to the College to obtain all reports prepared by his Physician Health Program ("PHP") workplace monitor pursuant to Dr. Gill's current contract with the PHP.
(n) Dr. Gill shall co-operate with unannounced inspections of his Practice Location(s) and patient charts by the College and to any other activity the College deems necessary in order to monitor compliance with the terms of this Order.
(o) Dr. Gill shall provide his irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the Narcotics Safety and Awareness Act, 2010 and any person or institution that may have relevant information, in order for the College to monitor his compliance with the terms of this Order.
(p) Dr. Gill acknowledges that the College may provide this Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where he practices or has privileges ("Chief(s) of Staff"), or other person or individual as necessary for the implementation of this Order and shall consent to the College providing to said Chief(s) of Staff, person or organization with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order and with his PHP contract.
(q) Dr. Gill shall comply with the terms of his current PHP contract and shall comply with any recommendations made by the PHP at the completion of the contract term in April 2020.

- Dr. Gill appear before the panel to be reprimanded.
- Dr. Gill pay costs to the College for a one day hearing in the amount of $5,000.00 within 60 days of the date of this Order.

3. Dr. G.M. MacNeil

Name:	Dr. Gerard Michael MacNeil
Practice:	Independent Practice
Practice Location:	Dorchester
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	December 20, 2016
Written Decision Date:	January 25, 2017

Allegations and Findings

- Found guilty of offence relevant to suitability to practice - **proved**
- Disgraceful, dishonourable and unprofessional conduct - **proved**

Summary

Dr. MacNeil, a general practitioner, practised in Dorchester, Ontario.

On March 5, 2010, Dr. MacNeil was criminally charged with defrauding the Ontario Health Insurance Plan (OHIP) of $483,915.65 for services not rendered between April 2007 and July 2008, contrary to Section 380(1)(a) of the Criminal Code of Canada.

On October 21, 2013, Dr. MacNeil pleaded guilty in the Ontario Court of Justice and was found guilty of the following provincial offences under the Health Insurance Act:

1. failing to maintain records as may be necessary to demonstrate that a service for which he prepares or submits an account is the service that he provided, contrary to section 37.1(2) of the Health Insurance Act, and thereby committed an offence pursuant to section 44 of that Act;
2. Between April 2, 2007 and June 18, 2009, knowingly obtaining or attempting to for any insured service that he was not entitled to obtain, contrary to Section 43(1) of the Health Insurance Act and thereby committed an offence pursuant to section 44 of the said Act.

Dr. MacNeil's convictions were made in the place of Criminal Code charges, and relate to the periods from April 1, 2007 to July 10, 2009, and April 2, 2007 to June 18, 2009, respectively.

Further to his guilty plea and conviction, Dr. MacNeil was ordered to pay a fine of $10,000.00 within 24 months, and to make restitution in the amount of $380,000.00 to

the Ministry of Health and Long Term Care at the rate of not less than $5,000.00 per month.

Despite having been criminally charged with defrauding OHIP under the Criminal Code of Canada on March 5, 2010, Dr. MacNeil answered "No" on May 30, 2010 to Question F. 4) in the College's 2010 Registration Renewal Form, received by the College on June 1, 2010. Question F. 4) asks: "Since April 1, 2009, have you been charged with any offence in Canada or elsewhere, the facts of which you have not previously disclosed to the College? (Include all offences under the Criminal Code of Canada, the Controlled Drugs and Substances Act, the Food and Drugs Act or the Health Insurance Act or related legislation in any Province or jurisdiction. In addition, include any other offences related to the practice of medicine.)"

Disposition

The Discipline Committee directed that there be no penalty in the circumstances of Dr. MacNeil's ill health.

Disgraceful, Dishonourable, or Unprofessional Conduct – 5 cases

1. Dr. C.P. Brand

Name:	Dr. Christopher Paul Brand
Practice:	General Practice
Practice Location:	Brechin
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	October 18, 2016
Written Decision Date:	December 14, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Brand, a family physician who currently practices in Brechin, Ontario, was the medical director of the Leacock Care Centre, a Long-Term Care Home licensed by the Ministry of Health and Long-Term Care ("MOHLTC") at the time of the incident described below.

One of the residents of the Centre, Patient A, was a man in his 70s with severe developmental delays since childhood and many serious behavioural challenges. Patient A is mostly nonverbal and has been in care for many years. Patient A often engaged in aggressive behaviour. This behaviour was described as being akin to

"temper tantrums." During these "tantrums," he was observed to throw and bang on objects, throw himself on the floor, scream, yell and cry, and hit or kick out around him.

On a date in November 2014, staff had been attempting to cut Patient A's beard, and Patient A refused. Staff asked Dr. Brand to assist because he had trimmed Patient A's beard before.

When Dr. Brand approached, Patient A dropped to the floor and began kicking. Dr. Brand grabbed Patient A's legs or feet and pulled him on the floor, up the hall to a conference room, which had previously been set aside as Patient A's bedroom. Neither Dr. Brand nor Patient A suffered any injuries in this incident.

At the time of the incident, residents were attending for breakfast and other activities in the area. The incident was observed by at least three staff members, including a nurse, as well as a compliance officer from the MOHLTC who happened to be in the building.

The nurse who observed the incident asked Dr. Brand to stop dragging the resident by his feet.

At that point, Dr. Brand had reached the door of the conference room. Dr. Brand was heard stating to Patient A, "you don't want to get your hair cut," as he pulled Patient A towards the conference room. Shortly after, Patient A exited the conference room, followed by Dr. Brand, who was holding hair clippers and an extension cord. Dr. Brand was heard to say, "guess the resident doesn't want his hair cut then."

Shortly after the incident took place, the Administrator of the Centre informed Dr. Brand that this would not be tolerated. Dr. Brand replied by indicating it was Patient A they were talking about and that he had been Patient A's doctor for many years.

Very soon after, however, Dr. Brand acknowledged to the Administrator of the Centre that he should not have dragged Patient A and that it was an error in judgment. He stated that, after Patient A fell to the floor, Patient A started kicking, and for that reason Dr. Brand grabbed his foot, "so he didn't hurt anyone or me."

At the time, Dr. Brand had recently undergone an abdominal surgery, and was concerned that Patient A's kicking might injure Dr. Brand. He therefore decided to restrain Patient A's feet and return him to his room.

Dr. Brand was terminated by the Leacock Care Centre on December 2, 2014.

Disposition

On October 18, 2016, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Brand's certificate of registration for a two month period, to commence at 12:01 a.m. on October 19, 2016.

- The Registrar impose the following as terms, conditions and limitations on Dr. Brand's certificate of registration:

a. At his own expense, Dr. Brand shall participate in and successfully complete, within 6 months of the date of this Order, individualized instruction satisfactory to the College and with an instructor approved by the College (the "Instructor"), on professional behavior and managing difficult patients. The Instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Brand; and
b. Prior to commencing individualized instruction, Dr. Brand shall engage in self-study in medical ethics, which shall include a literature review with a written report to be presented to, discussed with and reviewed by the Instructor.

- Dr. Brand appear before the panel to be reprimanded.
- Dr. Brand pay to the College its costs of this proceeding in the amount of $5,000.00 within thirty (30) days from the date of this Order.

2. Dr. F.A. DiPaola

Name:	Dr. Francesca Anne DiPaola
Practice:	Pediatrics
Practice Location:	Sudbury
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	October 27, 2016
Written Decision Date:	December 16, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Di Paola, a family physician, practices in the area of addiction medicine at the Centre for Addiction and Mental Health ("CAMH") in Toronto.

Dr. Di Paola had a close personal connection to Patients A and B. Both Patient A and Patient B have accessed services at CAMH. Patient A was an in-patient at CAMH between April and May 2014.

In February 2015, concerned about potential unauthorized access of his medical record by Dr. Di Paola, Patient B requested that a "lockbox" be implemented on his medical record at CAMH. A lockbox is a restriction on access to a patient's medical record, imposed at the request of the patient. In Patient B's case, he requested that access to his medical record be restricted to two specific physicians at CAMH. He also requested a list of all individuals who had accessed his CAMH medical record at any time.

On another date in February 2015, also concerned about potential unauthorized access of her medical record by Dr. Di Paola, Patient A requested that a lockbox be

implemented on her medical record at CAMH, on similar terms to those requested by Patient B. She also requested a list of all individuals who had accessed her CAMH medical record at any time.

Dr. Di Paola's access of medical records

Pursuant to Patient A's and Patient B's the requests, CAMH conducted an internal audit which revealed that Dr. Di Paola had accessed or attempted to access Patient A's medical records on 10 separate dates between May 2012 and August 2014. The audit also revealed that Dr. Di Paola had accessed or attempted to access Patient B's medical records on 9 separate dates between May 2012 and September 2014.

Dr. Di Paola did not have consent or any other legal authority to access the medical records of Patient A or Patient B on any occasion.

In CAMH's current database system, iCARE, which was implemented in May 2014, a physician must declare that he or she is in a treating relationship with the patient, and set out the nature of that relationship, in order to be granted permission to access a patient's medical records.

Dr. Di Paola attempted to access Patient A's medical records through iCARE on a date in August 2014. She did not declare a treating relationship with Patient A, and so was not granted access to Patient A's medical records on that date.

Dr. Di Paola attempted to access Patient B's medical records through iCARE on a date in September 2014. She did not declare a treating relationship with Patient B and so was not granted access to Patient B's medical records on that date.

When Dr. Di Paola accessed Patient B's medical records through iCARE on a date in September 2014, she declared herself to be an "Attending Physician" in order to gain access. On that date, Dr. Di Paola was the attending physician on the unit where Patient B was a patient, but she did not have his consent or legal authority to access his medical records. Dr. Di Paola also accessed Patient B's medical records through iCARE a few days later.

On a later date in September 2014, Dr. Di Paola, having previously been the attending physician on Patient B's unit, received an Inbox message sent to all of Patient B's physicians at CAMH. Dr. Di Paola did not access Patient B's medical records through iCARE on that date.

The medical records of Patient A and Patient B accessed by Dr. Di Paola included personal health information of a very sensitive nature, namely information related to psychiatric and addictions issues. Patient A and Patient B expected that this information would be kept confidential.

In the summer of 2014, Dr. Di Paola was invited to attend a meeting regarding Patient A's care at a hospital by virtue of Dr Di Paola's close personal relationship with Patient A. This meeting was attended by Patient A's treating physician and by a Children's Aid Society social worker who had been involved with Patient A's family. At that meeting, Dr. Di Paola took a position with respect to Patient A's access to Patient A's child that was adverse to the position taken on this issue by Patient A's treating physician.

CAMH Policies and Privacy Education

On December 10, 2012, Dr. Di Paola signed a letter of offer of appointment to the medical staff at CAMH. On April 17, 2013, Dr. Di Paola signed a letter of re-appointment to the medical staff at CAMH. Each letter provided that, by signing the letter, Dr. Di Paola confirmed that she was familiar with the Personal Health Information and Privacy Protection Act and was aware of, and agreed to honour, her obligations set out therein. Each letter also provided that acceptance of the appointment entailed Dr. Di Paola's agreement to govern herself in accordance with all CAMH Policies, which included a Privacy Policy.

Dr. Di Paola completed CAMH's e-learning program on Privacy Fundamentals on April 26, 2012 and again on August 31, 2014.

Dr. Di Paola was aware each time that she accessed the medical records of Patient A and Patient B that she was doing so without authority or consent.

CAMH Disciplinary Action

The Medical Advisory Committee at CAMH, where Dr. Di Paola holds privileges and where the breaches of privacy occurred, took disciplinary action against Dr. Di Paola. The disciplinary action consisted of a two-week unpaid leave of absence; the completion of two courses addressing issues relating to professional boundaries and privacy and confidentiality (the Boundaries course at the University of Western Ontario, and the Osgoode Hall Law School Professional Development course entitled "Legal Guide to Privacy and Information Management in Health Care"); and the drafting of three letters of apology, one to Patient A, one to Patient B and one to CAMH as an organization.

Disposition

On October 27, 2016, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Di Paola's certificate of registration for a period of three (3) months commencing at 12:00 a.m. on October 31, 2016;
- The Registrar impose the following term, condition and limitation on Dr. Di Paola's certificate of registration:
- Dr. Di Paola will participate in and successfully complete, within six (6) months of the date of this Order, five (5) hours of individualized instruction in medical ethics with an

instructor approved by the College, with a report or reports to be provided to the College regarding Dr. Di Paola's progress and compliance.
- Dr. Di Paola appear before the panel to be reprimanded;
- Dr. Di Paola pay costs to the College in the amount of $5,000.00 within 30 days of the date of this Order.

3. Dr. B.A. Pilarski

Name:	Dr. Barbara Anne Pilarski
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Contested Penalty
Decision Date:	October 31, 2016
Written Decision Date:	December 8, 2016

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Failed to maintain the standard of practice – **withdrawn**
- Incompetence - **withdrawn**

Summary

Dr. Pilarski, a family physician practicing medicine in Toronto, received her certificate of registration authorizing independent practice in Ontario in 1990.

Dr. Pilarksi provided home care visits to Patient A, an elderly patient. In the course of treating Patient A, Dr. Pilarski received and accepted gifts from her patient, including jewelry and money.

Patient A was a patient in Dr. Pilarski's office practice from 1991 until 2006. In 2006, Patient A asked Dr. Pilarksi to see her at home as it was difficult for Patient A to get to Dr. Pilarki's office. At the time, Patient A was in her 80s.

Dr. Pilarski agreed to make home care visits for Patient A beginning in 2006. Dr. Pilarski also took over care for Patient A's elderly husband and provided treatment to him at home from about 2008 until he was moved to a care facility in 2011. Patient A's husband died in 2013.

Dr. Pilarski continued providing home care visits to Patient A up until approximately 2014, when Patient A's adult child made a complaint to the College pertaining to Dr. Pilarski's dealings with her mother.

Between 2006 and 2014, Dr. Pilarksi treated Patient A for a variety of age-related health issues and primarily for long-standing anxiety and insomnia that were treated with medications, including Halcion, along with counselling from Dr. Pilarksi.

Patient A and her husband were financially well off and came into substantial money in approximately 2007.

In early 2014, Patient A's adult child requested that Dr. Pilarski return the gifts Patient A had provided to Dr. Pilarski over the years.

On January 16, 2014, Dr. Pilarski returned jewelry and other assorted items to Patient A's adult child. An evaluation concluded that some of these items amounted to $8,150.00.

Dr. Pilarski advised the College that she had kept all the items together over the years in order to return them at some point to the family.

Dr. Pilarski accepted a blank cheque from Patient A in the amount of $5,000.00, dated May 2010. Dr. Pilarksi inserted her husband's name on the cheque as payee. Dr. Pilarski used the money to buy a fireplace, chairs and artwork to create a spa like retreat for her patients in her waiting room. Dr. Pilarski returned the $5,000.00 to Patient A by way of a cheque dated October 13, 2016.

In the summer of 2010, Dr. Pilarski accepted a gift of a few hundred euros from Patient A to be used by Dr. Pilarski's children on a family vacation.

Disposition

On October 31, 2016, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Pilarski's Certificate of Registration for a three (3) month period effective immediately.
- The Registrar impose the following term, condition and limitation on Dr. Pilarski's certificate of registration:
  a. At her own expense, Dr. Pilarski shall participate in and successfully complete, within six (6) months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Pilarski.
- Dr. Pilarski appear before the panel to be reprimanded.
- Dr. Pilarski pay costs to the College for a one day hearing in the amount of $5,000.00 within 30 days of the date of this Order.

4. Dr. M.J. Podell

Name:	Dr. Marc Jeffrey Podell
Practice:	Independent Practice
Practice Location:	Mississauga
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	January 23, 2017
Written Decision Date:	February 1, 2017

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Marc Jeffrey Podell is a physician who received his certificate of registration authorizing independent practice in 1981. Dr. Podell practiced as a surgical assistant at Trillium Health Partners ("the Hospital") between 2003 and 2014.

Between 2008 and 2014, Dr. Podell was repeatedly inaccessible during his on-call periods. Dr. Podell did not respond to pages, was frequently late and/or did not attend for emergency surgery while he was on call. His conduct jeopardized patient care as surgeons in emergent cases were forced to proceed without assistance. Although Dr. Podell asserted that he encountered difficulties with his pager and cell phone, he took insufficient steps to address the issue such that he could be available to the physicians and staff of the Hospital, despite numerous attempts by the Hospital to address this ongoing problem.

Dr. Podell made repeated inappropriate comments in the operating room including commenting on the size and features of anesthetized patients. In April of 2009, Dr. Podell, while in the doctor's lounge, amidst other physicians, made inappropriate comments while looking at pictures of women on a website entitled "Asian Kisses".

In May of 2013 Dr. Podell approached an 18 year old patient four times in two days, aggressively requesting cash payment of his fee for assisting at her laparoscopic appendicitis surgery in the Paediatrics unit. The patient was upset by this experience. Both nursing and social work staff felt that his advances towards the patient were harassing. Dr. Podell conducted himself in this manner even though he had been told several years prior to this incident to refrain from repeat demands for immediate payment from Quebec patients for his services.

After speaking with the social worker who had assisted with the above incident, Dr. Podell inappropriately requested that she portray him in a more favorable light in her report.

In April of 2014, in the Operating Room, Dr. Podell bumped into Nurse X. Nurse X felt that the physical contact was intentional, and filed a complaint against Dr. Podell. Dr. Podell reported that the contact was unintentional. Dr. Podell was asked not to have any contact with Nurse X. Nonetheless, he attempted to do so on three occasions, which Nurse X found intimidating.

On May 7 of 2014 the Hospital suspended Dr. Podell's privileges. Dr. Podell subsequently resigned his privileges on May 14, 2016.

On January 23, 2017, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Podell's certificate of registration for a period of three (3) months, commencing immediately.
- The following terms, conditions and limitations be imposed on Dr. Podell's certificate of registration authorizing independent practice:

a) Upon his return to practice, Dr. Podell shall comply with the College's Changing Scope of Practice and/or Re-entering Practice policies, attached hereto as Appendix "A" and Appendix "B", if applicable.
b) Dr. Podell shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
c) Dr. Podell shall, at his own expense: enter into an agreement with the Physician Health Program (PHP), prior to returning to practice, which shall include workplace monitoring as recommended by the PHP and reports to the College every six months.
d) Dr. Podell shall comply with the agreement set out in (c) above.
e) Dr. Podell shall consent to information-sharing/reporting between the College and the workplace monitors, the PHP as well as any other persons necessary in order for the College to receive information relevant to his compliance with these or any other terms of the order.

- Dr. Podell appear before the panel to be reprimanded.
- Dr. Podell pay costs to the College in the amount of $5,000.00 by July 23, 2017.

5. Dr. M.B. Wilson

Name:	Dr. Murray Bruce Wilson
Practice:	Independent Practice
Practice Location:	Bradford
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	November 16, 2016
Written Decision Date:	December 15, 2016

Allegation and Finding

- Sexual abuse of a patient – **withdrawn**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Wilson is a family physician who has practised in Bradford, Ontario since 1985. Patient A was Dr. Wilson's patient beginning when she was a young child.

In December 2004, when she was in her teens, Patient A attended at Dr. Wilson's office because she was experiencing pain after having had intercourse earlier that day (dyspareunia). Her medical record indicates that on that day she was also complaining of dysmenorrhea and menorrhagia, as well as lower back pain of two months' duration, which was aggravated by bending. At a previous appointment, Dr Wilson had performed a breast examination and identified a lump that should be monitored.

At the December 2004 appointment, Dr. Wilson performed a clinically-indicated physical examination on Patient A, which included an examination of the chest, breasts, cardiovascular system, abdomen, and pelvis. Dr. Wilson took a vaginal swab, provided Patient A with a requisition for a urine test, and ordered a pelvic ultrasound. Dr. Wilson documented the examination in the patient chart.

Dr. Wilson also assessed Patient A's lower back at the appointment, which included asking that she stand and bend to 90 degrees. This assessment was clinically indicated and documented in the patient chart. Dr. Wilson noted in the chart that his impression was that Patient A had a lumbar strain.

Patient A was confused and distressed by this appointment as a result of Dr. Wilson's conduct during the appointment, which included the following:

- Dr. Wilson did not provide Patient A with a gown, but only with a drape, which was inadequate for the examinations performed. Patient A found it hard to cover herself sufficiently throughout the appointment. This left her feeling exposed and vulnerable.
- Dr. Wilson did not adequately explain the pelvic and breast examinations that he conducted to Patient A to obtain her informed consent. Patient A did not understand the purpose and steps involved.
- Although Dr. Wilson asked Patient A for sexual information relevant to the pain she was experiencing after intercourse, he did not explain the clinical basis for his questions. He asked her whether it hurt and how it felt when her boyfriend "went deep," and repeated the word "deep" several times. Patient A felt very uncomfortable.
- Dr. Wilson directed Patient A to bend over with her back to him, without explaining the clinical reason or seeking her consent. Patient A bent over as directed, but had only the drape to hold in place at her front, while her back (which was towards Dr. Wilson) was fully exposed, including her buttocks. Patient A did not understand the purpose of this examination and felt shocked and violated.

As a result, Patient A experienced great discomfort during the appointment. She returned to see Dr. Wilson on several more occasions but was not comfortable with him.

The experience made her more reluctant to seek medical care in general. In 2013, Patient A considered the continued impact of her experience with Dr. Wilson. Subsequently, Patient A decided to report her experience to the College.

Dr. Wilson is subject to an undertaking to the College into which he entered on January 13, 2012. It requires Dr. Wilson to have a practice monitor who is a regulated health professional acceptable to the College, who must carefully observe all of his examinations of female patients and remain in the examination or consulting room at all times during all professional encounters with female patients. The practice monitor is required to report on at least a monthly basis to the College. Dr. Wilson is required to post a sign regarding this restriction in his waiting room and all examination rooms, and there are various provisions to permit compliance monitoring.

Dr. Wilson entered into this undertaking at the College's request after the College received complaints about female patients' experiences in Dr. Wilson's office, including two instances in which Dr. Wilson moved the patient's clothing aside and commenced an examination without adequate explanation or consent.

In 2011, Dr. Wilson voluntarily completed a course offered by the University of Western Ontario on Understanding Boundary Issues and Managing the Risks Inherent in the Doctor-Patient Relationship.

Dr. Wilson's practice monitor has advised that she has not had concerns regarding his respect for female patients' boundaries and privacy.

The College has not received any complaints regarding conduct by Dr. Wilson towards female patients that has taken place since he entered into the 2012 undertaking.

Disposition

On November 16, 2016, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Wilson's certificate of registration for period of four (4) months, to commence at 12:01 a.m. on November 17, 2016.
- The Registrar impose the terms of Dr. Wilson's undertaking with the College dated January 13, 2012 as terms, conditions and limitations on Dr. Wilson's certificate of registration.
- Dr. Wilson appear before the panel to be reprimanded.
- Dr. Wilson pay to the College its costs of this proceeding in the amount of $5,000.00 within thirty (30) days from the date of this Order.

Conduct Unbecoming – 1 case

1. Dr. K. Johnston

Name:	Dr. Kevin Johnston
Practice:	Family Medicine
Practice Location:	
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	October 31, 2016
Written Decision Date:	December 14, 2016

Allegations and Findings

- Conduct unbecoming: **proved**
- Disgraceful, dishonourable and unprofessional conduct: **withdrawn**

Summary

On October 31, 2016, the Discipline Committee of the College of Physicians and Surgeons of Ontario found that Dr. Kevin Johnston engaged in professional misconduct in that he has engaged in conduct unbecoming a physician.

Dr. Johnston, a 44 year old family physician, was formerly known as Kevin Richard Speight, under which name he practised medicine until November 2014. He has not practised medicine since March 17, 2016.

Dr. Johnston has previously practised in Toronto, Cambridge, St. Catharines, and Mississauga. Most recently, in 2015 and 2016 he practised in Guelph and Kitchener.

Accessing, purchasing, and possessing child pornography

In October 2010, Dr. Johnston visited a website, Azov Films, which sold movies and photo collections, including child pornography. Dr. Johnston accessed and purchased child pornography depicting nude pubescent and pre-pubescent boys. Specifically,

- Before making his purchases, Dr. Johnston accessed child pornography on the Azov Films website, including flash video files and compressed container files with various movie trailers and JPEG images.
- On October 16 and 17, 2010, Dr. Johnston purchased 16 discs containing collections of photos from Azov Films. Fourteen of these photo discs contain child pornography.

- On October 16, 17, and 18, 2010, Dr. Johnston downloaded the photo discs described above to a computer in his home.

The Toronto Police identified orders that Dr. Johnston placed on the website to purchase photo collections and Dr. Johnston's downloads of the photo collections that he purchased. Dr. Johnston's purchases were also confirmed by Dr. Johnston's credit card statement, obtained by the College.

Dr. Johnston was acquitted of criminal charges in relation to the purchases described above on May 29, 2013. The Court found that the Crown had not led any evidence of an essential element of the offence, namely that Dr. Johnston knew the nature and content of the images that he ordered.

The College requested a further report from the Toronto Police Service addressing this issue, which it received in August 2015. The report confirms that Dr. Johnston was aware of the nature and content of the child pornography that he purchased, and in particular that he had accessed various movie trailers and images containing child pornography before he purchased photo collections.

The child pornography in issue in this case did not contain explicit sexual activity or violence.

Surreptitious video recording

During the execution of a search warrant at Dr. Johnston's residence on November 24, 2011, Toronto police seized an "Angel Eye" mini video recording system, a micro SD card, and an Apple iPhone. The video recording system was equipped with a small camera attached by a cord and an empty slot capable of housing a micro SD card.

The mini SD card contained four videos date stamped 2007.08.26. Two of the videos contained images of Dr. Johnston, his cat, and his residence.

The other two videos contained footage from a public bathroom. In particular, there was footage which Dr. Johnston had surreptitiously filmed of an unknown male defecating in a bathroom stall.

On the Apple iPhone, other videos and images were taken in public washrooms as well, including a surreptitious video which Dr. Johnston had made of a male urinating into a public urinal, made through a peep hole.

In 2012, after the events in issue, Dr. Kevin Johnston ("Dr. Johnston") was diagnosed with bipolar disorder.

Dr. Johnston entered into a recognizance of bail on November 25, 2011, after he was charged criminally. Among other things, it restricted Dr. Johnston from being alone with

anyone under 18 years of age, including while he practiced as a physician. His bail was varied on February 16, 2012 and March 1, 2012.

After the College was made aware of the charges against Dr. Johnston, an investigator was appointed pursuant to section 75(1)(a) of the Health Professions Procedural Code on March 20, 2012.

At the College's request, Dr. Johnston voluntarily entered into an undertaking on November 5, 2012 that mirrored the terms of his criminal recognizance, so that the College could monitor Dr. Johnston's compliance. This undertaking remained in effect after Dr. Johnston's criminal process came to an end.

After allegations against Dr. Johnston were referred to the Discipline Committee, the Inquiries, Complaints and Reports Committee of the College provided Dr. Johnston with notice that it intended to impose an interim order against him pending resolution of the discipline allegations.

In response, Dr. Johnston entered into a new voluntary undertaking (replacing the 2012 undertaking) dated March 17, 2016 which required him to have a College-approved practice monitor for all professional encounters with patients under the age of 18, until the allegations against him were resolved.

Subsequently, Dr. Johnston chose to cease practising medicine until the hearing.

Disposition

On October 31, 2016, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Johnston's certificate of registration, effective immediately.
- Dr. Johnston appear before the Panel to be reprimanded
- Dr. Johnston pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date of this Order.