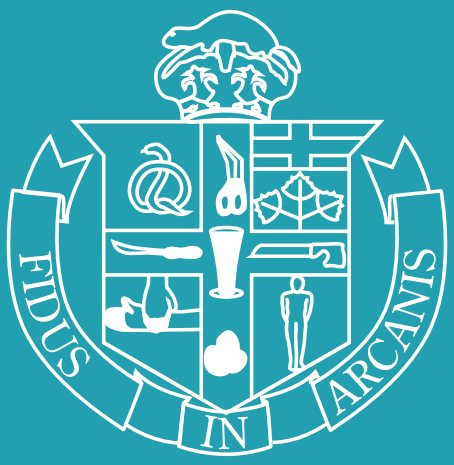
The College of Physicians and Surgeons of Ontario

Annual Financial Meeting of Council



MAY 25/26, 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 Thursday May 25 and Friday May 26, 2017 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m.

Rocco Gerace, MD
Registrar

April 28, 2017

Council Members

May 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Dr. David Rouselle
President
District 5
Representative

Dr. Steven Bodley
Vice-President
District 8
Representative

Mr. Sudershen Beri
Public Member

Dr. Brenda Copps
District 4
Representative

Ms. Lynne Cram
Public Member

Mr. Harry Erlichman
Public Member

Dr. Marc Gabel
District 10
Representative

Ms. Debbie Giampietri
Public Member

Mr. Pierre Giroux
Public Member

Dr. Rob Gratton
District 2
Representative

Dr. Deborah Hellyer
District 1
Representative

Major Abdul Khalifa
Public Member

Dr. Joel Kirsh
Past President
Academic
Representative
University of Toronto

Mr. John Langs
Public Member

Dr. Carol Leet
District 5
Representative

Dr. Barbara Lent
Academic
Representative
Western University

Dr. Richard Mackenzie
District 10
Representative

Dr. Haidar Mahmoud
District 10
Representative

NO PHOTO AVAILABLE

Mr. Roy Marra
Public Member

NO PHOTO AVAILABLE

Ms. Judy Mintz
Public Member

Dr. Akbar Panju
Academic
Representative
McMaster University
(non-voting)

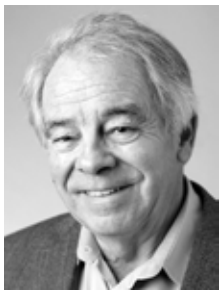
Mr. Peter Pielsticker
Public Member

Dr. Dennis Pitt
District 7
Representative

Dr. Judith Plante
District 7
Representative

Dr. Peeter Poldre
District 10
Representative

Ms. Joan Powell
Public Member



Dr. John Rapin
District 6
Representative

Mr. Arthur Ronald
Public Member

Dr. Jerry Rosenblum
District 3
Representative

Dr. Robert Smith
Academic
Representative
Northern Ontario School
of Medicine
(non-voting)

Ms. Gerry Sparrow
Public Member

Mr. Emile Therien
Public Member

Dr. Andrew Turner
District 9
Representative

Dr. James Watters
Academic
Representative
University of Ottawa

Dr. Scott Wooder
District 4
Representative

Dr. Janet van Vlymen
Academic
Representative
Queen's University
(non-voting)

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
May 25 and 26, 2017
Council Chamber, 3rd Floor, 80 College Street, Toronto

May 25, 2017

CALL TO ORDER

9:00 President's Announcements

9:05 Council Meeting Minutes of February 24, 2017……..……....**1**

Executive Committee's Report to Council, January to March, 2017……..**12**

9:10 2016 Audited Financial Statements and Appointment of the Auditor for 2017……**15**

- ***For Decision***

At the Annual Financial Meeting of Council, the College's auditor presents the audit report along with the audited financial statements for the year 2016. The Council will appoint the external auditors for the upcoming year.

Report of the Finance Committee ……**33**

- ***For Information***

The Committee's issues and activities for 2016 are included for review and discussion by the Chair, Mr. Pierre Giroux.

PRESENTATION

10:00 Data and Analytics Strategic Initiative……..……**41**

- ***For Discussion***

Council will be provided with an update on the development of the CPSO Data and Analytics Strategic Framework that outlines planned activities from 2017 to 2020 to move toward the desired goals.

10:15 ***Break***

PRESENTATION

10:30 Education Strategic Initiative – College Long-Term Vision for Education.....**45**

- ***For Discussion***

Council will consider the activities of the Visioning Group of the Education Strategic Initiative and will have the opportunity to review the draft Role, Vision and Goal for Education at the College.

10:45

REGISTRAR'S REPORT
Corporate Reporting and Dashboard – 2017 Q1

53

Divisional Reports:

1. Corporate Services ……....**61**
2. Information Technology ……..**74**
3. Investigations, Resolutions, Hearings, Compliance Monitoring and Supervision ……..**82**
4. Legal ……**112**
5. Policy and Communications……....**115**
6. Quality Management ……....**131**
7. Research and Evaluation……....**142**

COUNCIL AWARD PRESENTATION

11:30 Council Award Winner: Dr. William Gary Smith of Orillia, Ontario……..**158**

11:45 Motion to go In-Camera

IN CAMERA

12:00 – 1:30 ***Lunch***

PRESENTATION

1:45 Peer Assessment Redesign - Update on Implementation.....**159**

- ***For Discussion***

Peer Assessment Redesign is focused on improving the quality of peer assessments by creating procedures and tools to structure and standardize assessments within distinct disciplines. Council will be provided with a status update on the work and progress supporting the implementation of the redesigned peer assessment program.

PRESENTATION

2:00 CPSO Evaluation of Multi-Source Feedback (MSF).....**166**

- ***For Discussion***

Council will be informed of the key findings from the MSF evaluation, and of several ongoing CPSO and national initiatives. These findings, the current environment for MSF nationally, and Council's response to the evaluation will all contribute to the development of recommendations related to the CPSO's future use of MSF. Council is asked for feedback on the evaluation findings.

2:15 Annual Fire Drill and Evacuation Procedures **178**

The College is required to complete annual testing of fire drill procedures. Council will be participating in this evacuation process during the meeting.

2:45 Governance Report: Nomination/Election Process for 2018 Executive Committee **180**

2018 Executive Committee Election

- ***For Decision***

Public Member President

- ***For Discussion***

Appointments
- New Public Members of Council
- Other Appointments
- ***For Information***

Completion of 2018 Committee Interest Forms (for submission at Council Meeting)

Adjourn Day 1

May 26, 2017

CALL TO ORDER

9:00 President's Announcements

9:10 Accepting New Patients – Consultation Report and Revised Draft Policy..**220**

- ***For Decision***

The draft *Accepting New Patients* policy was released for external consultation following the December meeting of Council. Council is provided with a report on the feedback received during the consultation period, and proposed revisions made by the Working Group. Council is asked whether it approves the revised draft *Accepting New Patients* policy.

9:35 Ending the Physician Patient Relationship – Consultation Report and Revised Draft Policy……..**233**

- ***For Decision***

The draft *Ending the Physician-Patient Relationship* policy was released for external consultation. After reviewing the feedback received, the Policy Working Group has revised the draft policy. Council is asked whether it approves the revised draft *Ending the Physician-Patient Relationship* policy.

10:05 General By-Law Amendments – Compensation Committee……..**249**

- ***For Decision***

Council is being asked to amend the General By-law to eliminate the Compensation Committee as a standing committee of Council.

MEMBER TOPICS

10:10 ***Break***

PRESENTATION

258

11:00 The North American Opioid Crisis: An Overview

Guest Speaker: Dr. David Juurlink, Medical Toxicologist
The Hospital for Sick Children

Dr. Juurlink will review the genesis and scope of the North American opioid crisis, and discuss potential solutions that might be implemented to mitigate harm.

12:00 – 1:00 *Lunch*

PRESENTATION

1:00 OPIOIDS……**259**
Methadone Committee Transition
Opioid Strategy Framework

- ***For Decision***

This briefing note considers the current context, outlines the CPSO role and roles of others, sets out planned changes to the methadone committee and proposes a strategy framework to respond to the opioid crisis. Council is asked to approve the planned changes to the methadone committee and the strategy framework.

INFORMATION ITEMS

ADJOURNMENT

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

Motion Title: **Approval of Financial Statements for 2016**

Date of Meeting: **May 25, 2017**

It is moved by_____,

and seconded by_____, that:

The Council approves the financial statements for the fiscal year ended December 31, 2016 as presented (a copy of which forms Appendix "…" to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

Motion Title: **Appointment of the Auditors for 2017**

Date of Meeting: **May 26, 2017**

It is moved by_____,

and seconded by_____, that:

The Council appoints Tinkham & Associates LLP, Chartered Accountants, as auditors to hold office until the next financial meeting of the Council.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **May 25, 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: **2018 Executive Committee Election**

Date of Meeting: May 25, 2017

It is moved by_____,

and seconded by_____, that:

The Council appoints _____ (as President),

_____(as Vice President),

_____(as physician member),

_____(as public member),

_____(as public member),

and Dr. David Rouselle (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2017.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Accepting New Patients Policy

Date of Meeting: May 26, 2017

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy "Accepting New Patients", (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **By-Law Amendments Re Compensation Committee**

Date of Meeting: **May 26, 2017**

It is moved by_____,
and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 115:

By-law No. 115

1. Subsection 39(4) of the General By-Law is revoked and the following is substituted:

Executive Committee

39. (4) In order to fulfill its duties under subsection (3), the executive committee shall,

(a) consult with Council in respect of the performance of the registrar and with respect to setting performance objectives in accordance with a process approved from time to time by Council;

(b) ensure that the appointment and re-appointment of the registrar are approved by Council; and

(c) approve a written agreement setting out the terms of employment of the registrar.

2. Section 41 of the General By-Law is amended by revoking "8 Compensation Committee".

3. Section 47.3 of the General By-Law is revoked.

4. Section 4 of the General By-Law is amended by adding the following as subsection 4(8):

Expenses

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

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Ending the Physician-Patient Relationship Policy

Date of Meeting: May 26, 2017

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy "Ending the Physician Patient Relationship", (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Approval of Procedure for Administration of Registrar Employment, Compensation and Performance Reviews**

Date of Meeting: May 26, 2017

It is moved by_____,

and seconded by_____, that:

The Council approve the Procedure for the Administration of the Registrar/CEO's Employment, Compensation and Performance Reviews (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Opioids – Methadone Committee Transition

Date of Meeting: May 26 and 27, 2017

It is moved by_____,

and seconded by_____, that:

Council directs staff to proceed with the transition of the Methadone Committee from a by-law Committee to a specialty panel of the Quality Assurance Committee (QAC).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Opioids – Opioid Strategy Framework

Date of Meeting: May 26 and 27, 2017

It is moved by_____,

and seconded by_____, that:

Council approves the Opioid Strategy Framework, as set out in the briefing note attached as 'Appendix ' to these minutes.

PROCEEDINGS OF THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO FEBRUARY 24, 2017

Attendees:

Dr. David Rouselle (President)
Mr. Sudershen Beri
Dr. Steven Bodley
Ms. Lynne Cram
Ms. Diane Doherty
Mr. Harry Erlichman
Ms. Debbie Giampietri
Dr. Marc Gabel
Dr. Joel Kirsh
Dr. Carol Leet
Dr. Haidar Mahmoud
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Dennis Pitt
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watters

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

Regrets: Dr. Brenda Copps, Mr. Pierre Giroux, Major Abdul Khalifa, Mr. John Langs, Dr. Barbara Lent, Dr. Richard (Rick) Mackenzie

CALL TO ORDER

President's Announcements

Dr. David Rouselle called the meeting to order at 9:00 a.m., and welcomed members of Council and guests.

Council Meeting Minutes of December 1 and 2, 2016

01-C-02-2017

It is moved by Dr. Jerry Rosenblum and seconded by Mr. Sudershen Beri that:

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

1. To include Dr. Paul Garfinkel's name in the Discipline Committee Listing.

CARRIED

Special Teleconference Meeting Minutes of December 16, 2016

02-C-02-2017

It is moved by Dr. Marc Gabel and seconded by Dr. Deborah Hellyer that:

The Council accepts the minutes of the special teleconference meeting of the Council held on December 16, 2016.

CARRIED

FOR DECISION

Uninsured Services: Billing and Block Fees – Draft for Consultation

03-C-02-2017

It is moved by Mr. Sudershen Beri and seconded by Dr. James Watters 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 "A"** to the minutes of this meeting).

CARRIED

Governance Committee Report

04-C-02-2017

It is moved by Ms. Lynne Cram and seconded by Dr. Marc Gabel that:

The Council appoints Ms. Joan Powell to the Governance Committee for 2017.

CARRIED

College Oversight of Fertility Services – Consultation Report and Revised Draft Regulations

05-C-02-2017

It is moved by Dr. Carol Leet and seconded by Dr. Haidar Mahmoud 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.

CARRIED

Proposed Fee Increases – Consultation Report

By-Law #111 (Annual Fee)

06-C-02-2017

It is moved by Dr. Jerry Rosenblum and seconded by Ms. Debbie Giampietri 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;

CARRIED

By-Law #113 (Application Fees Increase for 2017)

07-C-02-2017

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

CARRIED

PRESENTATION

Practice Ready Assessment in Ontario (PRA)

Mr. Sten Ardal, Chief Executive Officer of Touchstone Institute, provided an overview of the Practice Ready Assessment program for family medicine, launching as a pilot program.

07-C-02-2017

It is moved by Dr. Deborah Hellyer and seconded by Ms. Joan Powell 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**.**

CARRIED

DISCUSSION – OPIOID UPDATE

Ms. Maureen Boon, Director Strategy, provided 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.

COUNCIL AWARD WINNER

Dr. Carol Leet presented the Council Award to Dr. Shazia Ambreen of Alliston, Ontario.

Motion to Go In Camera

08-C-02-2017

It is moved by Mr. Emile Therien and seconded by Dr. Marc Gabel:

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.

CARRIED

IN CAMERA

Council entered into an in-camera session at 1:00 p.m.. and returned to open session at 1:55 p.m.

FOR DECISION

Bill 87, Protecting Patients Act

Bill 87, the Protecting Patients Act was introduced in December 2016. Council was provided with an overview and analysis of the Bill along with possible implications for the College.

09-C-02-2017

It is moved by Dr. Carol Leet and seconded by Dr. Marc Gabel:

Council supports the analysis set out in section C of the briefing material (which forms Appendix **"B"** to the minutes to this meeting) with respect to Bill 87 and, the inclusion of the additional proposed legislative changes set out in Section D (which forms Appendix **"C"** to the minutes to this meeting) in College submissions pertaining to the Bill.

CARRIED.

REGISTRAR'S REPORT

Strategic Initiatives Including Dashboard Update.

MEMBER TOPICS

There were no member topics brought forward.

TOPICS FOR INFORMATION

1. Renewal of Third Pathway Status – Medical Psychotherapy Association Canada (MDPAC) (Formerly General Practice Psychotherapy Association (GPPA)

2. Policy Report

3. Medical Assistance In Dying Update

4. 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'

5. Government Relations Report

6. Discipline Committee – Feb 2017 Report of Completed Cases

Motion to Go In Camera

10-C-02-2017

It is moved by Dr. Peeter Poldre and seconded by Dr. Steven Bodley 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.

CARRIED

IN CAMERA

Council entered into an in-camera session at 2:45 p.m. and returned to open session at 3:25 p.m.

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 3:25 p.m.

_____
Dr. David Rouselle, President

_____
Franca Mancini, Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: Executive Committee's Report to Council
January 2017 – March 2017
In Accordance with Section 12 HPPC

FOR INFORMATION

January 17 , 2017 Executive Committee Meeting

1. Practice Ready Assessments in Ontario (PRA)

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 who are deemed practice ready.

The Executive Committee supports the Registration Committee's recommendation to issue a pre-entry assessment period type of certificate of registration for the purpose of the 12 week assessment, and a restricted certificate to practice under supervision for 24 months for the purpose of gaining exam eligibility (first 12 months) and writing the CFPC exam (next 12 months).

2. Renewal of Third Pathway Status – Medical Psychotherapy Association of Canada (Formerly GPPA)

The Medical Psychotherapy Association Canada, formerly the General Practice Psychotherapy Association (GPPA), is currently the only third pathway that has been approved to track CPD. The Executive Committee confirmed the Education Committee's decision to extend its status for three more years. 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.

3. Report of the Governance Committee – Request for Committee Appointment

The Executive Committee appoints Dr. Thomas Bertoia to the Finance Committee.

February 10, 2017 EXECUTIVE COMMITTEE MEETING

1. Bill 87 – Amendments to the RHPA and CPSO Positions

On December 8, 2016, Bill 87, the *Protecting Patients Act, 2016* was introduced. Schedule 4 of the Bill sets out the amendments to the *Regulated Health Professions Act* (RHPA). The College plans to provide government with its response to the Bill as soon as possible and to participate fully in the legislative process as the Bill moves forward.

The Executive Committee was provided with additional analysis of Schedule 4 the Bill, and considered options for responding to two areas of particular concern. As well, the Committee considered whether the College should request amendments in two areas that have not previously been part of a CPSO submission for legislative change. The Committee made the following recommendations:

(1) The Executive Committee, in order to provide for greater independence of the Discipline Committee, recommends that Council support a request to amend the statute concerning ministerial regulation-making power and the structure of statutory committees.

(2) The Executive Committee recommends that Council oppose the proposal in Bill 87 in regards to the ministerial regulation-making power to clarify how colleges perform their investigative and discipline processes and provide for additional functions and duties.

(3) The Executive Committee recommends that Council support the inclusion of two additional legislative requests as part of the CPSO's response to Bill 87:

1. Amendments to S. 36 to clarify ability to share non-nominal data for research/public health, and;
2. 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.

2. Report of the Governance Committee –Committee Appointment for New Public Member, Geraldine Sparrow

The Executive Committee appoints Geraldine Sparrow to the Discipline Committee.

March 21, 2017 EXECUTIVE COMMITTEE MEETING

1. The Executive Committee appoints Judy Mintz to the Inquiries, Complaints and Reports Committee.

Contact: David Rouselle, President
Vicki White, ext. 433

Date: May 10, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: 2016 AUDITED FINANCIAL STATEMENTS & APPOINTMENT OF THE AUDITOR FOR 2017

FOR DECISION/DISCUSSION

ISSUE:

Annual audit and audited financial statements for 2016

BACKGROUND:

The spring meeting of Council is the Annual Financial Meeting for the College. At this meeting the auditors present the audit report along with the audited financial statements.

As well, at this meeting, Council appoints the external auditors for the next year.

Mr. Dale Tinkham, of Tinkham and Associates LLP, reviewed the audited financial statements for the year ended December 31, 2016, comparing the actual expenditures to those of the previous year.

The auditor reported that the financial statements are represented fairly in accordance with Canadian accounting standards for not-for-profit organizations.

The report states:

“In our opinion these financial statements present fairly, in all material respects, the financial position of The College of Physicians and Surgeons of Ontario as at December 31, 2016, and the results of its operations and its cash flows for the year ended are in accordance with Canadian accounting standards for not-for-profit organizations.”

The Finance Committee made the following motion:

The Financial Committee recommends to Council that the Audited Financial Statements as presented by Tinkham and Associates LLP for the year ended December 31, 2016 be accepted as amended.

The Finance Committee also recommends to Council the following motion:

The Finance Committee recommends to Council that the firm of Tinkham and Associates LLP, Chartered Accountants be appointed as the College's auditors for the year 2017.

INTERNAL CONTROLS:

Each year, the Finance Department completes a document that details the College's internal controls in the following areas: General Business Environment; Information Technology; Financial Statement Presentation; Purchases; Payables and Payment Transaction Stream; Payroll Transaction Stream; Revenues; Receivables and Receipts Transaction Stream and Assets. The College's auditor uses this document to assist in determining the strength of the College's internal controls annually. The auditor stated "We have not identified any deficiencies nor developed any significant recommendations to improve internal controls or accounting procedures."

DECISIONS/DISCUSSION FOR COUNCIL:

The Finance Committee recommends approval of the audited financial statements for 2016 and further recommends the firm of Tinkham and Associates LLP be reappointed as the College's auditors for the year 2017.

Contact: Mr. Pierre Giroux, Chair of the Finance Committee
Mr. Douglas Anderson, Corporate Services Officer, ext. 607
Ms. Leslee Frampton, Manager, Finance & Business Services, ext. 311

Date: May 2, 2017

Appendices: Audited Financial Statements.

Financial statements of

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO OF ONTARIO

December 31, 2016

Tinkham & Associates LLP
CHARTERED ACCOUNTANTS

D C Tinkham, FCPA, FCA, LPA, CMC
Associates
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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of The College of Physicians and Surgeons of Ontario, which comprise the statement of financial position as at December 31, 2016 and the statements of operations and changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of The College of Physicians and Surgeons of Ontario as at December 31, 2016 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

TORONTO, Ontario
DATE

Licensed Public Accountants

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Financial Position

As at December 31	2016	2015
Assets		
Current		
Cash	**$ 27,333,907**	$ 28,097,450
Accounts receivable (note 3)	**933,950**	1,011,408
Prepaids	**436,647**	403,845
	28,704,504	29,512,703
Investments (note 4)	**50,543,913**	50,085,129
Capital assets (note 5)	**10,737,540**	10,726,155
	$ 89,985,957	$ 90,323,987
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 6,528,693**	$ 5,917,333
Due to Ministry of Health and Long Term Care	**-**	1,288,849
Administered programme (note 7)	**64,497**	152,978
Current portion of obligations under capital leases (note 9)	**386,815**	295,511
	6,980,005	7,654,671
Deferred revenue (note 6)	**27,528,513**	26,501,565
	34,508,518	34,156,236
Accrued pension cost (note 8)	**5,472,074**	5,445,028
Obligations under capital leases (note 9)	**491,199**	211,518
	40,471,791	39,812,782
Net assets (note 10)		
Invested in capital assets	**9,859,526**	10,219,127
Building fund	**39,654,640**	40,292,078
Unrestricted	**312,159**	197,648
Pension remeasurements (note 8)	**(312,159)**	(197,648)
	49,514,166	50,511,205
	$ 89,985,957	$ 90,323,987

Commitments and Contingencies (notes 11 and 12)

Approved on behalf of the Council

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Net Assets

Year ended December 31	**2016**	2015 (note 13)
Revenue		
Membership fees		
General and educational (note 6)	**$ 56,719,244**	$ 54,745,583
Penalty fee	**348,906**	371,501
	57,068,150	55,117,084
Application fees	**5,483,734**	5,276,453
OHPIP annual and assessment fees (note 6)	**1,215,732**	995,830
IHF annual and assessment fees (note 6)	**1,078,327**	1,140,568
OHPIP, IHF application fees and penalties	**71,685**	78,619
Cost recoveries and other income	**1,920,583**	2,179,027
Investment income	**1,015,005**	1,428,933
	67,853,216	66,216,514
Expenses		
Committee costs (schedule I)	**15,288,667**	14,262,194
Staffing costs (schedule II)	**43,485,099**	39,109,208
Department costs (schedule III)	**7,020,345**	6,389,811
Depreciation of capital assets	**1,270,931**	1,289,327
Occupancy (schedule IV)	**1,670,702**	1,542,677
	68,735,744	62,593,217
Excess (deficiency) of revenue over expenses for the year	**(882,528)**	3,623,297
Net assets, beginning of year	**50,511,205**	46,921,200
Actuarial remeasurement for pension (note 8)	**(114,511)**	(33,292)
Net assets, end of year	**$ 49,514,166**	$ 50,511,205

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	2016	2015
Cash flows from operating activities:		
Excess (deficiency) of revenue over expenses for the year	**$ (882,528)**	$ 3,623,297
Depreciation of capital assets	**1,270,931**	1,289,327
	388,403	4,912,624
Net change in non-cash working capital items:		
Accounts receivable	**77,458**	103,677
Prepaids	**(32,802)**	7,517
Accrued interest receivable	**(458,784)**	(85,129)
Accounts payable and accrued liabilities	**611,360**	985,623
Due to Ministry of Health and Long Term Care	**(1,288,849)**	-
Administered programme	**(88,481)**	(80,664)
Deferred revenue	**1,026,948**	992,878
Pension cost	**(87,465)**	(85,175)
Cash provided by operating activities	**147,788**	6,751,351
Cash flows from investing activities:		
Purchase of capital assets	**(463,880)**	(896,953)
Purchase of investments (net)	**-**	(9,051,162)
Cash used by investing activities	**(463,880)**	(9,948,115)
Cash flows from financing activities:		
Payment of capital lease obligations	**(447,451)**	(463,032)
Net increase (decrease) in cash	**(763,543)**	(3,659,796)
Cash, beginning of year	**28,097,450**	31,757,246
Cash, end of year	**$ 27,333,907**	$ 28,097,450

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements
December 31, 2016

1 Organization

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

The College is exempt from income taxes provided certain criteria are met.

2 Significant accounting policies

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

a) Cash

Cash includes cash deposits held in a major financial institution.

b) Investments

Guaranteed investment certificates are valued at amortized cost.

c) Capital assets

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

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. An impairment loss is recognized in the statement of operations when the carrying amount of the asset exceeds the sum of the undiscounted cash flows resulting from its use and eventual disposition. The impairment loss is measured as the amount by which the carrying amount of the capital asset exceeds its fair value. An impairment loss is not reversed if the fair value of the capital asset subsequently increases. As at December 31, 2016, no such impairment exists.

Amortization is provided for on a straight-line basis over their estimated lives as follows:

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

d) Pension plans

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

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

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

2 Significant accounting policies continued

e) Revenue recognition

i) Members' fees and application fees

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

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

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

iii) Investment income

Investment income is comprised of interest from cash and cash equivalents, and guaranteed investment certificates. Interest and dividends are recognized when earned.

f) Financial instruments

i) Measurement

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

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

Financial assets subsequently measured at amortized cost include guaranteed investment certificates and receivables. Financial liabilities subsequently measured at amortized cost include accounts payable and accrued liabilities, due to Ministry of Health and Long Term Care, and obligations under capital leases.

ii) Impairment

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

g) Management estimates

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

h) Net assets invested in capital assets

Net assets invested in capital assets comprises the net book value of the capital assets less the related obligations under capital leases.

3 Cancer Care Ontario Quality Management Partnership

The College and Cancer Care Ontario (CCO), are jointly developing a provincial quality management program in three areas: mammography, colonoscopy and pathology which are fully funded by CCO. The College has incurred expenses on behalf of CCO totaling $698,360 (2015 - $604,071) which are not included in these financial statements. As at December 31, 2016 there is $539,221 (2015 - $456,931) receivable from CCO which is included in accounts receivable. CCO has the right to audit the expenses charged to the program.

4 Investments

As at December 31	**2016**	2015
Guaranteed Investment Certificates (GIC)		
Bank of Montreal, 1.76%, due November 14, 2016	**$ -**	$ 10,000,000
Manulife Bank, 1.70%, due November 14, 2017	**10,000,000**	10,000,000
Manulife Bank, 1.95%, due November 13, 2018	**10,000,000**	10,000,000
CIBC, guaranteed growth, minimum 0.50% annual return, due November 13, 2019	**10,000,000**	10,000,000
CIBC, guaranteed growth, minimum 0.60% annual return, due November 13, 2020	**10,000,000**	10,000,000
National Bank, 2.01%, due November 22, 2022	**10,000,000**	-
Accrued interest to December 31	**543,913**	85,129
	$ 50,543,913	$ 50,085,129

The GIC investments are measured at amortized cost. Interest on the guaranteed growth investments held at CIBC will be determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest has been accrued at the minimum guaranteed rates.

5 Capital assets

As at December 31	**2016**		2015	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**20,735,933**	**14,134,456**	20,482,488	13,634,713
Furniture and fixtures	**4,357,209**	**3,384,491**	4,151,119	3,186,793
Computer and other equipment	**1,266,212**	**1,236,255**	1,261,867	1,206,894
Computer equipment under capital lease	**1,804,569**	**932,986**	1,249,542	748,944
Leasehold improvements	**396,339**	**277,437**	396,339	198,169
Website	**856,086**	**856,086**	856,086	838,676
	$ 31,559,251	**$ 20,821,711**	$ 30,540,344	$ 19,814,189
Net book value		**$ 10,737,540**		$ 10,726,155

6 Deferred revenue

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

	Membership Fees	IHF	OHPIP	2016 Total	2015 Total
Balance, beginning of year	**$ 23,669,620**	**$ 1,591,123**	**$ 1,240,823**	**$ 26,501,566**	$ 25,508,688
Amounts billed during the year	**57,332,536**	**1,436,555**	**1,271,159**	**60,040,250**	57,874,860
Less: Recognized as revenue	**(56,719,244)**	**(1,078,327)**	**(1,215,732)**	**(59,013,303)**	(56,881,982)
Balance, end of year	**$ 24,282,912**	**$ 1,949,351**	**$ 1,296,250**	**$ 27,528,513**	$ 26,501,566

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

7 Administered programme

The College administers the Methadone programme on behalf of the Ministry of Health and Long Term Care (MOHLTC). The revenues and expenses incurred for the programme are not included in the statement of operations of the College as they are the responsibility of the MOHLTC.

	2016	2015
Balance, opening	**$ 152,978**	$ 233,642
MOHLTC	**322,158**	342,473
Expenditures	**(410,639)**	(423,137)
Balance, closing	**$ 64,497**	$ 152,978

8 Pension Plans

i) Plan description

The College maintains a defined contribution pension plan for the benefit of substantially all of its employees. The College also sponsors a supplementary defined contribution retirement plan for employees of the College in order to supplement the pension benefits payable to employees which are subject to the maximum contribution limitations under the Canadian Income Tax Act.

In addition, the College maintains a closed defined benefit pension plan for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2016 Total	2015 Total
Plan assets at fair value	**$ 2,929,387**	**$ -**	**$ 2,929,387**	$ 3,243,210
Accrued pension obligations	**(3,987,128)**	**(4,414,333)**	**(8,401,461)**	(8,688,238)
Funded status - deficit	**$ (1,057,741)**	**$ (4,414,333)**	**$ (5,472,074)**	$ (5,445,028)

8 Pension plans continued

iii) Plan assets

Defined Benefit Plan	Funded Plan	Unfunded Plan	2016 Total	2015 Total
Fair value, beginning of year	**$ 3,243,210**	**$ -**	**$ 3,243,210**	$ 3,441,318
Interest income	**121,620**	**-**	**121,620**	129,049
Return on plan assets (excluding interest)	**(113,692)**	**-**	**(113,692)**	(5,314)
Employer contributions	**-**	**291,654**	**291,654**	291,311
Benefits paid	**(321,751)**	**(291,654)**	**(613,405)**	(613,154)
Fair value, end of year	**$ 2,929,387**	**$ -**	**$ 2,929,387**	$ 3,243,210

iv) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2016 Total	2015 Total
Balance, beginning of year	**$ 4,150,083**	**$ 4,538,155**	**$ 8,688,238**	$ 8,938,229
Interest cost on accrued pension obligations	**155,628**	**170,181**	**325,809**	335,185
Benefits paid	**(321,751)**	**(291,654)**	**(613,405)**	(613,154)
Actuarial (gains) losses	**3,168**	**(2,349)**	**819**	27,978
	$ 3,987,128	**$ 4,414,333**	**$ 8,401,461**	$ 8,688,238

The most recent actuarial valuation of the pension plan for funding and accounting purposes was made effective December 31, 2015. In accordance with that valuation, no payments have been made or are required under the funded plan. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2018.

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

	2016	2015
Funded defined benefit plan	**$ 34,008**	$ 31,558
Unfunded supplementary defined benefit plan	**170,181**	174,577
Defined contribution plan	**2,765,209**	2,540,336
Supplementary defined contribution plan	**193,179**	187,321
	$ 3,162,577	$ 2,933,792

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2016 Total	2015 Total
Interest cost on accrued pension obligations	**$ 155,628**	**$ 170,181**	**$ 325,809**	$ 335,184
Interest income on pension assets	**(121,620)**	**-**	**(121,620)**	(129,049)
Pension expense (recovery) recognized	**$ 34,008**	**$ 170,181**	**$ 204,189**	$ 206,135

8 Pension plans continued

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2016 Total**	2015 Total
Actuarial (gain) losses	**$ 3,168**	**$ (2,349)**	**$ 819**	$ 27,978
Return on plan assets (excluding interest)	**113,692**	**-**	**113,692**	5,314
Charge (credit) to net assets	**$ 116,860**	**$ (2,349)**	**$ 114,511**	$ 33,292

viii) Actuarial assumptions

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

	2016	2015
Discount rate	**3.66 %**	3.75 %
Rate of compensation increase	**N/A**	N/A

9 Obligations under capital leases

The College has entered into several capital leases for computer equipment. The following is a schedule of the future minimum lease payments of the obligations under these leases, at an effective average rate of 1.68% interest, expiring on various dates to November 2020:

2017	$ 389,171
2018	266,576
2019	189,656
2020	34,967
Total minimum payments	880,370
Less: amount representing interest	2,356
	878,014
Less: current portion	386,815
	$ 491,199

10 Net assets

2016	Invested in Capital Assets	Building Fund	Unrestricted	Pension Re-measurement	Total
Balance, January 1	**$10,219,127**	**$40,292,078**	**$ 197,648**	**$ (197,648)**	**$50,511,205**
Excess (deficiency) of revenue over expenses for the year	**(359,601)**	**-**	**(522,927)**	**-**	**(882,528)**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(114,511)**	**(114,511)**
Transfers	**-**	**(637,438)**	**637,438**	**-**	**-**
Balance, December 31	**$ 9,859,526**	**$39,654,640**	**$ 312,159**	**$ (312,159)**	**$49,514,166**

2015	Invested in Capital Assets	Building Fund	Unrestricted Net Assets	Pension Re-measurement	Total
Balance, January 1	$10,148,468	$36,772,732	$ 164,356	$ (164,356)	$46,921,200
Excess of revenue over expenses for the year	70,659	-	3,552,638	-	3,623,297
Actuarial remeasurement for pensions	-	-	-	(33,292)	(33,292)
Transfers	-	3,519,346	(3,519,346)	-	-
Balance, December 31	$10,219,127	$40,292,078	$ 197,648	$ (197,648)	$50,511,205

The College has transferred $637,438 from the building fund to unrestricted net assets (2015 - $(3,519,346) transferred to the building fund from unrestricted net assets).

Net assets invested in capital assets is calculated as follows:

As at December 31	**2016**	2015
Net book value of capital assets	**$ 10,737,540**	$ 10,726,155
Less: obligations under capital leases	**(878,014)**	(507,028)
	$ 9,859,526	$ 10,219,127

11 Commitments

The College has extended their lease for additional office space to December 31, 2021 with two options to renew for additional five year terms subsequent. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each of the next five years are estimated as follows:

2017	$ 619,305
2018	691,587
2019	716,394
2020	724,475
2021	732,717
Total	$ 3,484,478

12 Contingencies

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

The College acknowledges that it has an obligation to provide funding to patients who are approved by the Patient Relations Committee.

13 Comparative figures

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

14 Financial instruments

General objectives, policies and processes

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

Credit risk

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

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

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

Liquidity risk

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

Market risk

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

Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College has nominal exposure to foreign exchange risk.

14 Financial instruments continued

Interest rate risk

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

Equity risk

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

Changes in risk

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule I
Committee Costs

Year ended December 31	**2016**	2015 (note 13)
Attendance	**$ 4,011,557**	$ 3,685,883
Preparation time	**3,031,900**	2,732,775
Decision writing	**978,582**	905,294
Expert opinions	**1,481,904**	1,577,743
Assessors	**342,309**	368,994
Travel time	**1,718,558**	1,681,383
HST on per diems	**601,856**	486,260
Legal costs	**1,498,452**	1,397,637
Audit fees	**38,092**	35,719
Sustenance	**316,577**	235,803
Meals and accommodations	**390,895**	333,657
Travel expenses	**847,685**	765,246
Witness expenses	**30,300**	55,800
	$ 15,288,667	$ 14,262,194

Schedule II
Staffing Costs

Year ended December 31	**2016**	2015 (note 13)
Salaries	**$ 34,489,020**	$ 31,410,406
Employee benefits	**4,571,881**	3,874,236
Pension (note 8)	**3,162,577**	2,933,792
Training and employee engagement	**670,103**	560,936
Personnel, placement and pension consultants	**591,518**	329,838
	$ 43,485,099	$ 39,109,208

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule III
Department Costs

Year ended December 31	2016	2015 (note 13)
Consultant fees	**$ 1,069,231**	$ 787,129
Credit card service charges	**1,253,249**	1,204,105
IT Projects - external partners	**424,475**	154,106
Software	**265,693**	162,792
Equipment leasing	**110,894**	71,554
Equipment maintenance	**39,937**	104,295
Miscellaneous	**393,576**	531,796
Photocopying	**357,756**	416,680
Printing	**37,341**	52,637
Postage	**294,698**	301,713
Members dialogue	**380,297**	399,265
Courier	**118,228**	118,876
Telephone	**315,305**	269,683
Office supplies	**340,251**	347,284
Reporting and transcripts	**353,184**	255,864
Professional fees - staff	**82,039**	92,178
FMRAC Membership fee	**471,000**	469,860
Publications and subscriptions	**191,780**	200,710
Travel, conferences, workshops and seminars	**447,411**	375,284
Grants	**74,000**	74,000
	$ 7,020,345	$ 6,389,811

Schedule IV
Occupancy

Year ended December 31	2016	2015
Building maintenance and repairs	**$ 465,192**	$ 426,221
Insurance	**496,566**	449,721
Realty taxes	**78,236**	78,486
Utilities	**246,055**	216,332
Rent	**384,653**	371,917
	$ 1,670,702	$ 1,542,677

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: REPORT OF THE FINANCE COMMITTEE

FOR INFORMATION

ISSUE:

Activities of the Finance Committee since the last Report of the Finance Committee to Council.

BACKGROUND:

The Finance Committee has met twice in 2017. Attached is a Report of the Finance Committee detailing the issues discussed at the meetings.

DECISIONS/DISCUSSION FOR COUNCIL:

For Information

Contact: Mr. Pierre Giroux, Chair of the Finance Committee
Mr. Douglas Anderson, Corporate Services Officer, ext 607
Ms. Leslee Frampton, Manager, Finance & Business Services, ext 311

Date: May 2, 2017

Appendices: Report of The Finance Committee

REPORT OF THE FINANCE COMMITTEE

HIROC (Health Insurance Reciprocal Insurance of Canada)

The Committee reviewed the College's reciprocal insurance coverage with HIROC. This has afforded the College decreased premiums and increased coverage (when compared to traditional insurance). As well, when the reciprocal makes a surplus, the College may share in any disbursement. The insurance covers the College's employees, councillors, officers, committee members, summer students and peer assessors. In addition to various coverages for liability there is traditional coverage for crime and property damages as well as Errors and Omissions and Directors and Officers and cyber-crime.

FIRMS (FMRAC'S Integrated Risk Management System)

All subscribers to the College's insurer are required to participate in a risk management self-appraisal of their programs and premises in an effort to proactively control risk. The completion of these modules leads to reductions in insurance premiums. The College self-assesses Governance, Operations, Registrations and Licensure, Complaints and Resolutions, Quality Assurance of Medical Practice and Facility Accreditation/Quality Review programs. This program will provide continuing analysis of risks and mitigation strategies for the College to scrutinize.

FINANCIAL STATEMENTS

Financial statements and variances were reviewed at each meeting of the Committee.

FINANCE COMMITTEE OF TERMS OF REFERENCE

The Finance Committee reviewed an enhanced Committee Terms of Reference. This document details best practices for the Finance Committee's oversight of the College's financial matters. The document is still in the process of being revised and will be furthered reviewed at its October 11, 2017 meeting. This document will assist in developing the Finance Committee's work plan.

FINANCE COMMITTEE WORK PLAN FOR 2017

The Committee reviewed and approved the work plan (attached) for 2017 to ensure the Committee is meeting it responsibilities in stewardship of the College's financial commitments and obligations.

BUDGET OBJECTIVES FOR 2018

The Committee discussed the historical membership fee increases noting that in the past number of years, the increase has not exceeded the inflation rate.

BUSINESS CONTINUNITY

The Business Continuity Plan development continues to proceed in consultation with al divisions.

COST SAVINGS INITITATIVES

Physician Compensation Working Group

The cost for physician participation at the College is significant and involves Council, Committee members and other individuals that serve in expert roles (eg. assessors). In 2016, the expenses for these roles in the College were approximately 17% of our 64M budget. These expenses consist primarily of per diems, hotel, sustenance, and travel expenses as well as other out of pocket expenses. A second factor contributing to costs is the number of members that sit on committees and panels. Finally, there is the cost of assessors in various programs that also contribute to overall expenses for physician participation. The Finance Committee established a working group that will review both how physicians are compensated and the number of members that sit on committee and panels. This group is comprised of the Chair of the Finance Committee, the immediate Past President and a former member of Council along with staff support and will review physician compensation.

Administrative and Purchasing Practices Review Group

The Committee reviewed the Terms of Reference for this working group and the progress made to date. This was established to review internal administrative practices and determine cost efficiencies that can be gained through employment of specific initiatives. The group is comprised of both managers and staff. Several initiatives have already been identified and steps taken to recognize cost efficiencies.

PCI COMPLIANCE (Payment Card Industry Data Security Standards)

The Committee was informed that staff have made the necessary changes to ensure the College is in compliance with the Payment Card Industry Data Security Standards. This is a contractual standard for the protection of data regarding credit cards issued by major card brands, including VISA, MasterCard and American Express.

TENDERING THE DEFINED CONTRIBUTION PENSION PLAN AND THE STAFF BENEFIT PROGRM

The Committee was informed that staff are in the process of tendering the services for the Recordkeeper for the Defined Contribution Pension Plan and the staff benefit program with the goal of gaining efficiencies and saving costs.

FMRAC FEE

The Committee was informed that the College has had a reduction in its membership fee with FMRAC.

SPACE

The Committee continues to be updated regarding the space needs of the College and the initiative to have Deloitte complete a workplace strategy review, which will look at short, medium and long range goals for new space.

FINANCE COMMITTEE WORK PLAN - 2017

Goal: a financially stable organization with control processes in place to appropriately manage all relevant College matters.

✓	Objective is complete	●	Work in Progress and on schedule	▲	Work in Progress but may not meet the target date	⬢	Work on Hold, will not meet target.

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
Ensure College Meets Operating Goals						
Oversee the development and approval of the 2018 budget	Discuss with Management the parameters for the 2018 budget	At the spring meeting, the Finance Committee will provide guidelines and direction for Management to follow in preparing 2018 budget.	Spring	April 4	●	At the spring meeting, the committee reviews the budget process. The budget is divided into two stages: 1) the base budget and 2) the business cases for new projects, staffing, etc.
	Review and comment on proposed budget	At the fall meeting, the proposed budget is submitted to the Committee for discussion and feedback on the appropriateness of the budget and implication to the fees required to fund the operation	Fall	Oct 11	●	Finance Committee is given the budget detail at the fall meeting. At that meeting the Finance Committee will review base budgets and assumptions and meet with department heads requesting new projects, staffing and capital projects
	Present Budget to Council for approval	Once the Committee has reviewed and makes any changes to the budget it will recommend to Council that the budget be approved.	Fall	Nov 30/Dec 1	●	Finance Committee will be recommending to Council the acceptance of the budget
Ensure all Council decisions are fully reflected in financial projections	Review all major College initiatives	Each initiative recommended to Council by the Finance Committee shall be accompanied by a Financial Impact Analysis and Business Case.	On-going	April 4 Oct 11	●	At each meeting of the Finance Committee any new initiatives with budget implications will be presented for review.
Ensure plans are in place to provide adequate space for College operations	Continually monitor real estate market for long-term permanent solutions for future expansion	Keep the committee up to date regarding potential opportunities for space	On-going		● ▲	Funds have been directed to the College's building reserve to assist in savings for future building needs. The Committee agreed to transfer any surplus funds to the building reserve. Staff is continually reviewing options with regards to acquiring space.
On-going review of the financial statements	The Committee will be provided the latest financial statements at spring & fall meetings. The Committee will receive Financial	A variance analysis will be provided explaining the large variances between the actual expenditures versus the budget allocation.	Spring & Fall	April 4 Oct 11	●	

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
	Statements and a variance report in the summer and winter so that the Committee will have quarterly financial information					
Ensure the College continuously improves business processes and achieves cost savings.	Review management report on College process improvements annually	Feedback provided to Management on continuous improvement program	On-going	Work in Progress		The IT Steering Committee regularly reviews the IT priorities at the College. When a project is undertaken part of the development of the new system or a change to an existing system is to complete a process review to ensure the changes contribute to continuous program improvement and efficiencies
Financial Indicators and Ratios						
	Working Capital	Ensure the College has enough money to cover its current obligations	1:1	0.78:1		This ratio measures the ability of an organization to pay its current obligations. The major contributing factor to the decrease of 0.6 is that, this is the time of year that the bank balance is drawn down to pay for expenses. The annual renewal process begins in mid-April which will increase our bank balance.
Ensure that Risk Management Processes are in Place						
Monitor development of a formal risk management program at the College	Submit RMSAM modules for 4-year review as required for regular cycle	The HIROC risk management program ensures that the College has a risk assessment program in place	2014/15			The RMSAM program is evolving to FMRAC Integrated Risk Management Systems (FIRMS). This new program is designed specifically for the Medical Regulatory Authorities (MRAs) and will be implemented in the near future. To date, we have received a 5% discount applied to our insurance premiums.
Ensure College's short term investments are managed appropriately	Review recommendations from Management regarding the investment of the short term funds.	Invest College's short-term funds prudently and ensure the best rate of return at the lowest risk to preserve capital.	Ongoing			This is revenue from the annual membership fees. Currently, it resides in the College's current account; however, it also may be in Government of Canada Treasury bonds (depending on the highest net interest rate). We are currently receiving 1.65% from our current account at Scotiabank.
Ensure College's long term investments are managed appropriately	Review recommendations from Management and 3rd party consultants regarding the asset mix of the longer term investments.	To position the portfolio in a manner that could be utilized to fund any capital projects such as a new building and to protect our capital	Fall	Nov 2017		The Finance Committee recommended to and Council approved the transfer of longer term investments from the current asset mix to a 5 year ladder GIC - including a GIC for one, two and three years and a 4 and 5 year market linked GIC. A $10,000,000 will come due in November and will be reinvested for 3 years
Ensure College's maintain its fiduciary responsibility to the Defined	Chair of the Finance Committee sits on the Pension Committee and is kept apprised of	To ensure that the pension plans are administered in compliance with the Pension Benefits Act and Financial Services	On-going			Council delegated the oversight of the College's pension plans to the Executive Committee, who in turn delegated to the Finance Committee. The Finance Committee has direct oversight of the Defined Benefit Pension Plan. The

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
Benefit Pension Plan and the Defined Contribution Pension Plan	the issues	Commission of Ontario requirements				Defined Benefit Plan is review every three years to determine the financial status of the plan. It should be noted that the Defined Benefit Plan is closed. There are 12 retired members and 1 inactive member. The Finance Committee has delegated the administration of the College's Defined Contribution Pension Plan to the Pension Committee. There is Finance Committee, management representation on this committee and staff representatives who are elected by their peers.
A Guide to Financial Statements of Not-for-Profit Organizations	Review questions developed by the Canadian Institute of Chartered Accountants	To ensure the Finance Committee has an understanding of how to read and interpret financial statements	On-going			The Canadian Institute of Chartered Accountants has developed a guide to understanding financial statements for not-for-profit organizations.
Business Continuity Plan	Work continues in updating the current Business Continuity Plan to current best practices.	A business continuity document that is comprehensive but easy to use and implement	On-going			In 2011 the College developed a business continuity plan. The plan needs to be updated to reflect current best practices. The College engaged the services Marsh Risk Consulting to assist in this process. Once the plan has been drafted the Finance Committee will review
Ensure Proper Financial Safe-Guards in Place						
Ensure College operates in compliance with generally accepted accounting principles and not for profit rules	Review and comment on the results of the annual external audit. Meet in camera with External Auditors to discuss the results of the audit.	Comments provided to auditor.	Spring	April 4		The College's audit firm, Tinkham & Associates will review the audited financial statements for the year ended December 31, 2016 comparing the actual expenditures to those of the previous year. The Committee will hold an in camera meeting with the Auditor at the Spring meeting.
	Arrange for auditor to present results of audit to Council.	Audit report presented to Council	Spring	May 25/26 Council		College's external auditor to present 2016 audited financial statements to Council
Internal Control Questionnaire	Each year staff in conjunctions with the external auditor, will update an internal control questionnaire that assesses the strength of the internal controls at the College	Confirms the strength of the internal controls at the College	Spring	April 4		The Finance Committee is responsible for maintaining oversight for management's efforts to create a strong control environment. Best practices dictates that the Finance Committee's review should include an evaluation of management's risk assessments and processes for identifying and addressing business and fraud risks.
Conflict of Interest and Code of	Ensure at each meeting that Committee	Declaration to be noted in the minutes.	Each meeting	Each meeting		Any conflicts of interest would be noted in the minutes

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
Conduct for individuals sitting on Finance Committee	members declare any potential conflicts of interest					
Ensure Adequate Orientation/Education for Members						
Ensure all Committee members are adequately trained and have appropriate tools to fulfill their Committee responsibilities.	Prepare a detailed orientation/ education document	Members receive education as needed	On-going	Jan 17, April 4, Oct 11		Continuous education throughout the year from various consultants and investment managers.
	Develop a glossary of financial terms	Glossary provided to Committee members		Complete		The glossary is updated on an on-going basis.
	Hold an annual formal orientation session for members	The objective is to brief new members regarding the financial matters of the College, and bring them up to date with the existing members of the Committee.	Jan 18	Jan 18		An orientation/education was held on January 18, 2017
	Role/Mandate of Committee	Ensure that the Committee members understand the role and mandate of the Committee	On-going	Each meeting		The Chair of the Committee ensures that the members of the Committee understand the role and mandate of the Committee and address any educational needs
	Timely distribution of materials	Ensure materials are distributed to the Committee in a timely manner	Each meeting	Each meeting		
	Development and strengths	Receive feedback from Committee regarding any development or educational needs.	Each meeting	Each meeting		

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: DATA AND ANALYTICS STRATEGY UPDATE

FOR INFORMATION

ISSUE:

- Data and Information Management was approved as a strategic initiative by Council as a component of the CPSO Strategic Framework for 2015 – 2018.
- This briefing note provides an update on the development of this activity since its initiation in May 2016 and presents the CPSO Data and Analytics Strategic Framework draft that outlines the activities from 2017 to 2020 to move toward the desired goals.
- The Data and Analytics Strategic Framework draft is presented to Council at this meeting (Appendix A).

BACKGROUND:

- In February 2016, the Registrar reported to Council that the mandate of the Data and Information Management Strategy is to “re-evaluate how the College collects, manages, uses and releases data”.
- CPSO collects a vast amount of data about members and operational processes from various sources. A streamlined data and analytics system will enhance CPSO’s ability to fulfill its mandate. The purpose of a Data and Analytics Strategic Framework is to pave the way towards harnessing the data collected at CPSO to support evidence-based decision making and to understand future needs. In particular, an intentional focus on data and analytics would allow the College to support its mandate by:

  - Routinely using data and evidence to better support operational and programmatic decisions
  - Proactively identifying and developing supportive and mitigating strategies for potential system or external risks
  - Maintaining confidence that our programs are effective and our operations are efficient
  - Enhancing the corporate commitment of transparency
  - Testing new ideas and creating the evidence to know if they work
  - Continuing to develop data literacy and capacity building

- By December 2016, a dedicated staff consultation team developed the Data and Analytics Strategic Framework draft that outlines the vision and mandate of the strategy, the current state, the desired state and defined activities over the next five years to move toward the desired state (Appendix A).

- In order to make the development work manageable, the scope of the Framework does not initially focus on communication, human resources or finance data, nor does it encompass a technological review of current IT structures.

CURRENT STATUS:

The Data and Analytics Strategy is defined within the College's 2017 corporate plan. The objectives are to develop a 3 to 5-year strategic framework focused on data and analytics, and begin to implement projects to support evidence-based decisions, College initiatives, and to support current program operations. In particular, the commitments for this year are:

- To create a strategic framework to guide the development of quality data for analytics.

- To develop and implement data development projects including a data inventory, a data mapping exercise and documentation by College business areas.

- To promote the use of data, evidence and best practice information management principles across the College by implementing phased in projects.

- To develop the capacity for data and informatics within the College and to seek external partnerships for analytics where necessary.

CONSIDERATIONS:

- A Data and Analytic Strategic Framework draft has been developed and is attached for your review. The implementation of discrete and feasible projects in this area has already begun.
- No new resources will be contemplated for this initiative at this time.
- Data-focused collaboration with external partners, where appropriate, will continue as considered and planned.
- Implementation of the Strategy will be through projects that are managed and feasible.

NEXT STEPS:

- Implementation will be supported by staff and phased in, based on departmental readiness.
- Committees will have the opportunity to participate in this Strategy as implementation unfolds.

INFORMATION FOR COUNCIL:

1. This presentation provides an update for Council.

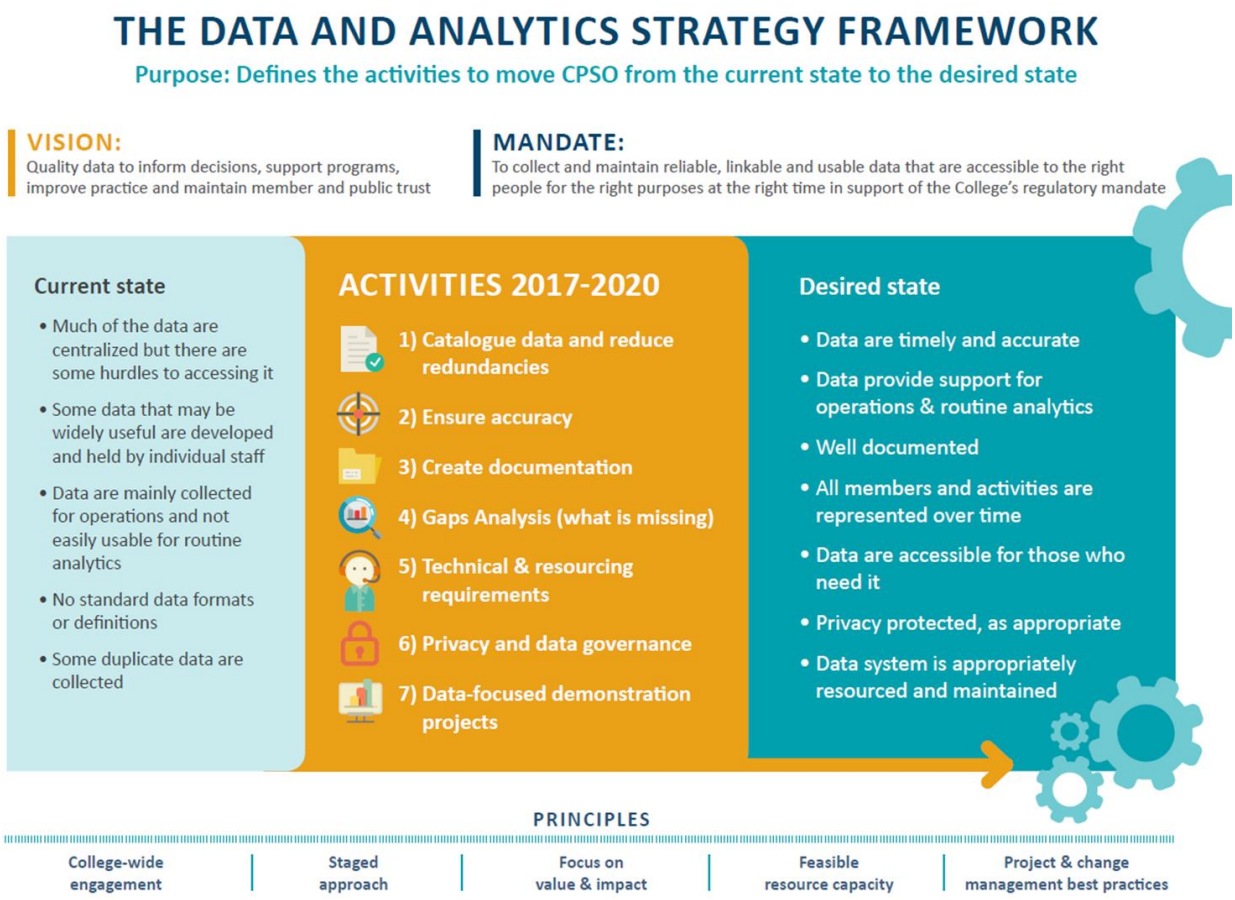
Contact: Karey Iron, ext. 767

Date: May 5, 2017

Appendix:

A. Data and Analytics Strategic Framework draft

Appendix A


THE DATA AND ANALYTICS STRATEGY FRAMEWORK
Purpose: Defines the activities to move CPSO from the current state to the desired state
VISION:
Quality data to inform decisions, support programs, improve practice and maintain member and public trust
MANDATE:
To collect and maintain reliable, linkable and usable data that are accessible to the right people for the right purposes at the right time in support of the College's regulatory mandate
Current state
• Much of the data are centralized but there are some hurdles to accessing it
• Some data that may be widely useful are developed and held by individual staff
• Data are mainly collected for operations and not easily usable for routine analytics
• No standard data formats or definitions
• Some duplicate data are collected
ACTIVITIES 2017-2020
1) Catalogue data and reduce redundancies
2) Ensure accuracy
3) Create documentation
4) Gaps Analysis (what is missing)
5) Technical & resourcing requirements
6) Privacy and data governance
7) Data-focused demonstration projects
Desired state
• Data are timely and accurate
• Data provide support for operations & routine analytics
• Well documented
• All members and activities are represented over time
• Data are accessible for those who need it
• Privacy protected, as appropriate
• Data system is appropriately resourced and maintained
PRINCIPLES
College-wide engagement
Staged approach
Focus on value & impact
Feasible resource capacity
Project & change management best practices

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: Education Strategic Initiative – College Long-term Vision for Education

DATE: May 25, 2017

For Information

ISSUE:

Council is being updated on the Education Strategic Initiative visioning exercise and being given the opportunity to review the draft Role, Vision and Goal for Education at the College.

BACKGROUND:

- In September 2014, Council approved four Strategic Initiatives for 2014-2017: Transparency, Quality Management Partnership (QMP), Data Management and Education.
- The purpose of the Education Strategic Initiative (ESI) was to integrate and coordinate physician education across all College Committees, programs and staff and to ensure consistency with respect to physician needs assessment, educational activities/resources, data collection, outcome measurement and reporting.
- The short-term focus was individualized education processes for physicians, and work underway relating to Professionalism.
- The long-term vision was to ensure the CPSO had effective and integrated mechanisms to measure and understand how educational activities contribute to changes in physician behaviour for best possible practice and ultimately best patient care.

CURRENT STATUS:

- ESI is comprised of 4 main components:

1. Developing a long-term vision and goal for education at the CPSO;
2. A new credentialing requirement for new applicants involving education and orientation to professionalism and professional regulation;

3. The development of an evidence-informed approach to remediation of physicians with identified issues in communication and professionalism, along with an evaluation strategy to look at the approach; and

4. Educational data tracking and management.

Since 2014, considerable work has been done to create a map of current educational activities at the College and develop a draft Role, Vision and Goal for Education at the College.

ROLE, VISION AND GOAL FOR EDUCATION AT THE CPSO

ROLE

The role of the CPSO in education describes where the organization fits in the medical education enterprise. The role is targeted both internally and externally to give stakeholders a fulsome understanding of how we expect and intend to contribute to the education of learners and physicians.

DRAFT Role for the CPSO in Education:

The CPSO is recognized as a key collaborator* in the education of physicians and learners with a goal of quality and safe patient care.

*Collaborators include, among others, National Certifying Colleges, Medical Schools, Specialty Societies, Physicians and Learners.

- The important concepts in this definition are “recognized”, “collaborator” and “full spectrum”.
- “Recognized” implies that external educational stakeholders consider the CPSO to be an organization that is deeply involved in many aspects of medical education.
- “Collaborator” is meant to describe that we are not generally a primary provider of education, but are a resource and partner in the educational enterprise.
- “Full spectrum” recognizes our involvement in medical education from entry to medical school to retirement.
- The Role emphasizes that we are involved in medical education in order to fulfill our regulatory mandate.

VISION

The *Vision* for education at the CPSO represents our long-term aspiration for being involved in medical education.

Draft Vision for Education at the CPSO

The CPSO engages physicians in effective life-long learning to support its vision of quality professionals, healthy system and public trust

- The *Vision* is fully aligned with the vision of the organization in the current strategic plan
- The focus of the vision is to emphasize the importance of the ongoing education of physicians through their careers as an important component of our regulatory activities.

GOAL

The *Goal of Educational Activity* at the College describes measurable elements of our educational activity that are important to for us to focus on to be involved in education in an effective way.

The Goal of Educational Activity at the CPSO

CPSO activity in medical education engages Ontario physicians and learners, is evidence-informed, systematically implemented, consistent, evaluated, and aligned with and connected to the broader health education system.

- The *Goal* has multiple elements upon which we can focus our energy for the creation of activities that will connect our current state (draft education activity map) to our desired state (the Goal) in order to accomplish our vision.
- *"targeted to engage"* refers to our desire to actively promote life-long education to both physicians and learners.
- *"physicians and learners"* refers to our interest in the full spectrum of medical education
- *"evidence-informed"* indicates that our educational activity (e.g development of Individualized Education Plans or the development of remedial programming) will be

based upon sound principles of adult education and the best available evidence as to how physicians can effectively change the practice behaviour.

- *"systematically implemented"* refers to ensuring that the implementation of education required by will be done in a consistent and defined fashion in every instance.

- *"consistent"* refers to the importance of promoting consistent committee educational decisions, both within and between committees.

- *"evaluated"* refers to the concept that we will continually (implied) monitor our activity to determine the effectiveness of both processes and outcomes with a goal to improve our approach.

- *"aligned with and connected to"* describes the importance of our educational activity being consistent with that which is going on in broader medical education and that we partner with external educational stakeholders.

NEXT STEPS:

- Staff will continue to develop a long-term strategy for education at the College by considering, developing and prioritizing activities in education that need to take place in order to take the College from our current state (Appendix A) to our desired state (Goal and Vision).

- Staff will have the strategy completed by the end of 2017.

- Other elements of ESI are in progress. Council will hear an update on the credentialing requirement and the professionalism education elements at a future meeting.

Contact: Dr. Bill McCauley, Extension 434

Date: May 2, 2017

Appendices:

Appendix A: Current Education Activities Map

APPENDIX A: MAP OF CURRENT CPSO ACTIVITIES IN EDUCATION

	REACTIVE		DATA	PROACTIVE	
Activity Stream	**Supporting MS Committee Decisions involving education**	**Supporting Individualized Physician Education**	**Collecting and Analysing Educational Data**	**Supporting Members with their CPD**	**Delivering Professionalism and Regulation Education**
Objectives	*To ensure all education elements of committee decisions are evidence-informed, consistent, achieving desired outcomes and evaluated.*	*To support individual physicians in addressing identified learning needs.*	*To ensure systematic tracking of learning needs, interventions and outcomes for program improvement and sharing with the system.*	*To ensure members are supported in participating in meaningful, effective and individualized CPD.*	*To support students and physicians throughout their professional careers by providing education on professionalism, professional regulation and current topics of interest*
Projects and activities	Follow up on relevant recommendation from 2014 IEP Analysis	Ongoing work of MAs and staff to support physicians with Educational and Remedial requirements	Follow up on data recommendations from 2014 IEP Analysis	Annual tracking of responses to Annual Renewal survey and following up on self-reported non-compliant members	Policy Dept's *Professionalism and Practice Program* – Undergraduate Medical Education
	Decisions with education by MS Committees (including Orders, SCERPs, Undertakings, Remediation Agreements, Decision letter)	MA interviews under MSF evaluation	Current project on ICRC-CanMEDS coding	Working with national educational Colleges to ensure members are fully participating in and compliant with CPD requirements	Physician education about professionalism and regulation through *Dialogue*, CPSO website, and social media

	REACTIVE		DATA	PROACTIVE	
Activity Stream	Supporting MS Committee Decisions involving education	Supporting Individualized Physician Education	Collecting and Analysing Educational Data	Supporting Members with their CPD	Delivering Professionalism and Regulation Education
	IPE Development by MAs	Legal staff negotiating educational Undertakings	I & R Recidivism study	Identification of unperceived physician learning needs through CPSO processes	Proposed credentialing requirement for new applicants Information services by PPAS
	Ongoing review of education decision making by Registration Committee	Multiple activities to support physicians by Investigators in I&R	Educational data mapping to support Data strategic Initiative	Supporting members with ongoing maintenance of CPD/PI section on website	Representation on UE and PG COFM
	Scoping review of best practices for remediation of professionalism and communication issues	Supporting Reg Com study plans and meetings with Registrar	Opioids and Medical Records educational data projects	Accreditation Working group to identify certification and credit opportunities for members	Planning for Educational Initiatives related to Opioid Prescribing
	Current project to develop evaluation framework for MS decisions that include remediation of prof and communication issues				
	Training of staff and Committees on issues related to education			Reporting on CPSO projects in FMEC – CPD (Future of Medical Education Canada)	
	Development and maintenance of internal CPD site to support Committee decision making				

	REACTIVE		DATA	PROACTIVE	
Activity Stream	**Supporting MS Committee Decisions involving education**	**Supporting Individualized Physician Education**	**Collecting and Analysing Educational Data**	**Supporting Members with their CPD**	**Delivering Professionalism and Regulation Education**
	Ongoing liaising with education providers and consultants			Participation in CPDO and CPD-COFM	
	Supervision Lead project plan for supervisor recruitment, training and evaluation	Liaising with External Partners providing education: Western Boundaries U of T Medical Records U of T Opioid Prescribing ProBE Canada			
To Explore	• Physician Practice Improvement – FMRAC • Physician Factors Project • Mandatory education for members on CPSO identified topics				

	REACTIVE		DATA	PROACTIVE	
Activity Stream	**Supporting MS Committee Decisions involving education**	**Supporting Individualized Physician Education**	**Collecting and Analysing Educational Data**	**Supporting Members with their CPD**	**Delivering Professionalism and Regulation Education**
Foundational Activities	• Integration of CanMEDS • Assessment • Evaluation • Stakeholder engagement with system stakeholders				

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **Corporate Report and Dashboard – 2017 Q1**

DATE: **May 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.

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 College's strategic and operational activities. Progress towards the goals set out in both the Strategic and Corporate Plans is reflected in the attached Corporate Report and Dashboard for Q1, attached at Appendix B.

DECISION FOR COUNCIL: For information only

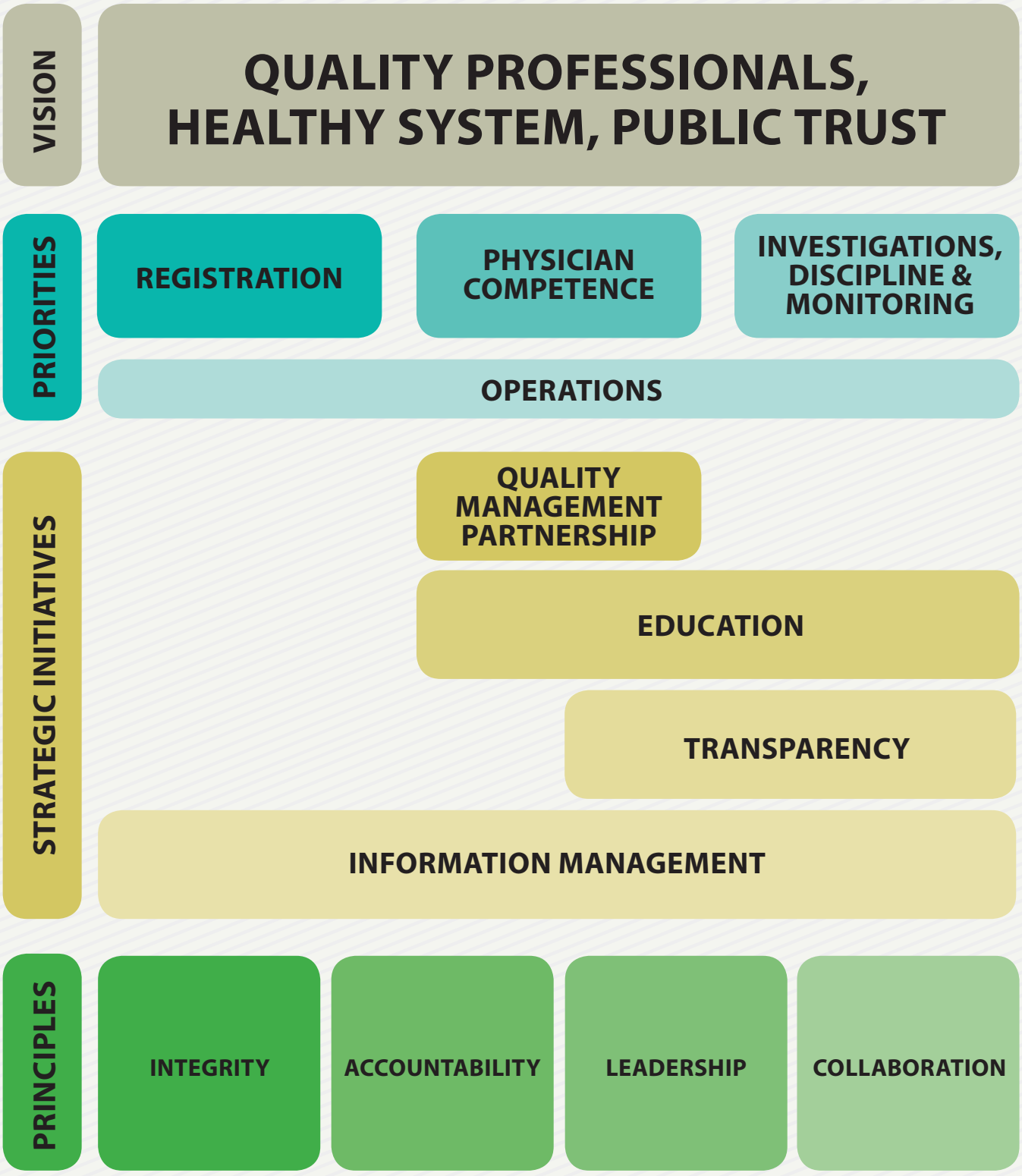
Contact: Rocco Gerace
Maureen Boon, ext 276

Date: May 5, 2017

Appendices:
A: Strategic Framework
B: Corporate Report and Dashboard – Q1

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO



Corporate Report – 2017 – Q1

Strategic Initiatives	Objective(s)	Status
Quality Management Partnership	Consistent high quality in mammography, colonoscopy and pathology across the province Integrated performance standards at the provider, facility and system levels	Data anticipated in 2017 Harmonization of QMP &CPSO processes to occur in 2017 Once complete, QMP will transition from a strategic initiative to a CPSO program
Education	Ensuring medical education related to the CPSO's regulatory activities is targeted, evidence-informed, and evaluated so that physicians are engaged in life-long learning and CPD	Multiple projects underway Vision/role/goals to Council in May 2017 New member orientation to be considered in Sep 2017
Transparency	Improving transparency of process, outcome and member information Website improvements to FindaDoc and Premises Register	Evaluation report to be completed by end 2017 Website improvements to be completed by fall 2017
Data & Analytics	To develop quality data for analytics to support evidence-based decisions, College initiatives and operations and business	Data & Analytic strategic framework to Council in May 2017

Regulatory Initiatives	Objective(s)	Status
Facilities/Premises	Improved facilities oversight	ART & HARPA regulation/implementation in development Facilities legislation outstanding.
Investigations/Hearings/Monitoring	Process improvements Monitoring of Goudge recommendations & SATF response	To be considered as part of Bill 87
Registration	Modernization of registration regulation, including integration of pathways	Plan to be developed in 2017
Assessments	Every doctor assessed every 10 years (EDEX) Peer assessment redesign implementation	EDEX Strategy Revamp in 2018 MSF evaluation to Council in May 2017 Peer Redesign update to Council in May 2017
RHPA Review	To work with government to achieve best possible legislation relating to sexual abuse, transparency and committee structure	Bill 87 submission made

Risk Initiatives	Objective(s)	Status
Infection Control	Ensure risk level monitoring and processes in place to manage/minimize risk	Processes in place
Opioids	Improved ability to identify and respond to unsafe opioid prescribing Improved opioid prescribing	Investigations ongoing Draft strategy framework to Council in May 2017
Physician Factors	Understand the demographic, practice & environmental physician factors to inform effective programs and enhance quality practice	Work ongoing
Regulatory Modernization (Governance)	Provide regulatory expertise to government to shape regulatory structure in 2017 and beyond.	Proposal to increase separation of DC to Council in May 2017

		Collaboration with AGRE on governance issues

Dashboard – 2017 – Q1

Strategic Priority	Objective	Measure/Target	Q1	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks		Credentials Applications: 1,275 applications of 1302 is 98% Registration Committee Applications: 325 of 353 applications is 92%
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year		487 assessments initiated – 19% of the annual target of 2600
	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
	Increase input in policy	130 responses/policy		Three policy consultations generated an average of 94 responses: Accepting New Patients (87), Ending the Physician-Patient Relationship (86) and Block Fees and Uninsured Services (108).

Strategic Priority	Objective	Measure/Target	Q1	Comments
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years		75% of are either current (have been reviewed in the last 5 years) or under review.[2] Some policy reviews have been deferred pending external factors, such as the Sexual Abuse Task Force and legislation, or to help support/respond to time sensitive or competing priorities.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.		Jan 1 – Mar 31, 2017: 90% of high risk investigations were completed in an average of 168 days, (20 investigations involving 9 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year		Jan 1 – Mar 31, 2017: 90% of hearings (9) began on average, 344.2 days (11.3 months) from the NOH date
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>		Jan 1 – Mar 31, 2017: 90% of uncontested decisions (8) were released , 34.8 days (1.1 months) from the last hearing date
		<u>6 months for contested (C)</u>		Jan 1 – Mar 31, 2017: 90% of contested decisions (4) were released, 170.3 days (5.6 months) from the last hearing date.

[1] Does not include registration policies
[2] Excludes registration policies

Strategic Priority	Objective	Measure/Target	Q1	Comments
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)		A&C 6,603 of 8,406 - 79% live answer PPAS 11,165 of 12,084 - 92% live answer Combined 17,768 of 20,490 - **87% live answer**
	Improve service level targets	10% call abandonment		A&C 1,298 calls abandoned - 17% PPAS 569 calls abandoned - 5 % Combined 1,867 calls abandoned **9%**
	Media coverage	80-100% positive or neutral		Of the 363 stories, the tone of the news coverage was good overall, as follows: 23% positive (82 stories); 61% neutral (222 stories); and 16% negative (56 stories).

APPENDIX B

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%

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2016 DIVISIONAL REPORT

Corporate Services Division

Corporate Services Division
Report to Council – 2016

<u>Corporate Services Division includes the Following Departments</u>:

A. Human Resources:

- HR strategic alignment, recruitment, annual performance, total rewards, legislative compliance, workforce planning, employee engagement and retention, benefits, training, development and orientation, health and wellness, HR online services and employee relations.

B. Records Management and Archives:

- Services include: development of policies and procedures which provide direction to staff on the effective management of records and provision of training in these best practices; organization of departmental shared drives to facilitate retrieval of information; creation of records retention schedules to improve accountability and record availability; management of all College contracts and agreements; file retrieval from on-site and off-site (including PC, MIF, Evidence records & Registration files), library reference and retrieval, and general assistance in locating information across the College.

C. Facilities:

- Maintenance Services
  - Facilities helpdesk is a central maintenance service that deals with all building-related maintenance items such as temperature issues, plumbing, lighting, custodial duties, offices moves, meeting room arrangements, life safety testing and ergonomics installations.

- Meeting/Event Services
  - Services include: all aspects of on-site meetings for committees, council and other College-related business. This includes teleconferencing equipment/set-up, projection equipment, video conferencing, food and beverage service and all lunches.
  - Extensive planning for meetings and events that take place in the building. Many events now include external organization planning

with which the College is connected to improve relations with external stakeholders.

- This department has expanded responsibilities to off-site events and in organizing external conferences. Many departments now work with the support and guidance from Meetings and Events Services.

- Security Services
  - Services include: reception screening; issuing security ID; communicate security procedures; coordinate parking requests for meetings and staff; answer inquiries from the membership regarding application processes; provide assistance in all emergencies whether medical, fire safety or building.

D. Finance and Business Services:

- Financial Services
  - Financial Services include: Budgeting, Investments, Accounts Payable, Accounts Receivable, Payroll, Financial Statements, Pensions, Audit, Financial Information and Purchasing.

- Business Services – Print Shop
  - Print Shop services include: photocopying, scanning and fax machines, point of contact for floor photocopiers and the delivery of paper.

- Mail Room Services
  - Services include: the delivery and pick-up of mail and tracking courier packages and hand-delivered items that arrive at the front desk.

A. HUMAN RESOURCES

Mission Statement

The Human Resources Department contributes to the success of the College by providing a balanced, impartial and confidential experience, and by providing effective policies and programs that create a healthy and supportive work environment where employees can feel fully engaged in the important work they do.

Vision

To support College core business to protect the public by providing innovative, cost effective and value added HR programs and services that align to College goals and priorities.

Employee Turnover

	2015 YR		2016 1Q		2016 2Q		2016 3Q		2016 4Q		2016	
Voluntary	16	4.4%	6	1.7%	4	1.1%	8	2.8%	5	1.0	23	5.8%
Involuntary	3	0.8%	4	1.1%	1	.02%	0	1.4%	4	1.0	9	2.3
Retirements	0	0.0%	2	0.1%	3	1.1%	2	1.7%	0	0	7	1.8
TOTAL	**19**	**5.3%**	**12**	**3.4%**	**8**	**2.5%**	**10**	**5.9%**	**9**	**2.0**	**39**	**9.8**
Turnover in I&R was unusually high at 17%, mainly due to retirements. Hiring Investigators continues to be a challenge.												

Number of Positions Recruited (posted)

2015 YR	2016 1Q	2016 2Q	2016 3Q	2016 4Q	2016
53	31	8	8	11	58

Average Number of Sick/Personal Days

	2015	2016 1Q		2016 2Q		2016 3Q		2016 4Q		2016	
	Avg.	**Days**	**Avg.**	**Days**	**Avg.**	**Days**	**Avg.**	**Days**	**Avg.**	**Days**	**Avg.**
Personal	n/a	202	0.6	188	0.5	163	0.4	209	0.5	762	2.1
Sick	n/a	414	1.2	300	0.9	268	0.7	320	0.8	1302	3.5
Total	**5.6**	**616**	**1.7**	**488**	**1.4**	**431**	**1.1**	**529**	**1.3**	**2064**	**5.6**
(12 eligible days)											

Notes:	
Public sector annual average	**10.5**
Private sector annual average	**6.4**

Short Term Disability Claims

	2015	2016 1Q	2016 2Q	2016 3Q	2016 4Q	YTD claims 2016
Number of new claims	23	7	5	2	3	17
All claims - days at full pay	644	209	115	60	45	429
Average days per claim	36.6	29.8	23.0	30	15.0	29.4

Notes:
The number of stress related claims has dropped since moving to a third party adjudicator and adjusting short-term disability procedures. There were no stress related claims in 2016.

Average Time to hire (days)

	2015 3Q, 4Q and **2016 1Q** (Averages of individual recruitments during this period)	**2016 2Q** (Averages of individual recruitments during this period)	**2016 3Q**	**2016 YR**
Time to Post Position	4.80	4.83	3.33	**4.32**
Sourcing Duration	12.20	12.50	17.17	**14.0**
Time to Present Shortlist	5.30	5.67	3.50	**4.8**
Time to Interview	7.10	12.20	9.33	**10.4**
Time to Choose Successful Candidate	2.70	3.33	5.75	**5.13**
Days to Complete References	3.00	2.33	2.00	**2.1**
Time to Fill	**29.50**	**39.33**	32.67	**40.75**

Performance Results

	2015		2016	
	Employees	**Merit**	**Employees**	**Merit**
Unsatisfactory			0%	0%
Satisfactory Development Required	1%	1.4%	8%	.5%
Solid Meets Expectations	75%	2.8%	70%	2.5
High Exceeds Expectations	24%	3.8%	21%	3.5
Outstanding			2%	4.5
Notes: **All employee performance assessments moved to November 1, 2016 under a new system. The new PA tool appears to be working as designed – recalibrating performance expectations and performance ratings while recognizing high performers. Performance ratings fell within industry benchmarks and aligned well with the new salary plan**				

B. Records Management and Archives (RMA)

RMA objectives and activities are directed by the CPSO's 4th strategic priority: "maintain ongoing operations and continuous quality improvement". Within this strategic priority, the specific mandate for the RMA department is to develop and implement a comprehensive management program for all College records with the purpose of realizing the following objectives:

a. Support College accountability and efficiency,
b. Ensure that all legal and business requirements with regards to record keeping are met,
c. Mitigate legal risks by development of records management policies and best practices
d. Support staff in their work by providing direction for best records practices that will facilitate quick access to required information,
e. Provide staff with timely access to records within RMA custody and to published information on relevant issues.

The components of this comprehensive records program and the program activities undertaken and completed by the RMA department in 2016 are as follows:

1. Develop and implement strong corporate records policies and practices to provide staff with direction on the management of College information; and provide training on implementation of these policies:
    - Developed, communicated via a series of videos, and implemented a corporate email management policy which guides staff on the effective management of their emails.
    - Developed and implemented a records liaison programme whereby a person in each department has been identified and trained to monitor records practices in his/her department and to liaise with RMA in the case of records issues and concerns
    - Managed **College contracts/agreements** and tracked a range of data elements to follow-up with agreement obligations.
        - **Number of contracts/agreements managed and tracked: 1061**
    - Changed business processes of QMD Committee support staff to achieve completely electronic documentation of committee activities, thereby facilitating retrieval of information and saving on off-site storage expenses
    - Implemented the process for confirming that retired council and/or committee members and assessors have destroyed or deleted all CPSO information in their possession, thus ensuring confidentiality of CPSO information
        - **Number of people contacted: 48**

2. Facilitate access to, and retrieval of, College information found in all formats and media:
    - Continued working on classification of departmental shared drives on the W drive in order to improve retrieval of information and to enable compliance with business, legal and retention requirements.
    - Implemented our annual process for destruction according to approved retention schedules of off-site paper records, of in-office paper files and electronic College files on shared drives as well as destruction according to signed data sharing agreements of electronic data received from, or shared with external sources.

    - **Number of boxes destroyed in compliance with our records retention schedules: 366 boxes**
    - **Number of records groups for which the eligible electronic documents were deleted: 65 record groups**
- Answered reference requests from both external and internal clients;
    - Number of external requests: 20 requiring circa 10 hours of work
    - Number of internal requests: 40 requiring circa 110 hours of work

3. Facilitate access to, and retrieval of, information found in external journals, newspapers, databases and other external sources to support College activities and decision-making:
    - Populated and maintained the CPSO virtual library which at the end of 2016 provided staff access to **39 journals, 12 databases** and corporate subscriptions to 2 internationally acclaimed newspapers.
    - Answered **206 research and reference requests**.
    - Conducted **19 training sessions** on use of CPSO virtual library.
    - Published a bi-weekly newsletter on relevant publications and disseminated it to 100 stakeholders.
    - Sent out table of Contents e-alerts for 40 key healthcare research and policy journals.
    - Reviewed the references in the Quality Improvement Resources for Family Medicine, Walk-in Clinics, Cardiology, Endocrinology and for Hospitalists.

4. Provide staff timely access to all on-site and off-site records required to execute business functions and take measures to ensure that documentation of corporate record holdings are accurate:
    - Provided staff with registration files as required 3 times daily.
        - **Number of transactions in the first floor file room: 82,758.**
    - Provided staff with on-site investigative files and evidence files as required twice a week.
        - **The number of transactions for these files was 10,442**
    - Provided staff with off-site files as required at least once a week.
        - **The number of retrievals of off-site files: 1727.**

- Conducted annual registration file recall to ensure that all registration files are accounted for, resulting once again in **0 registration files unaccounted for.**
- Conducted an audit of off-site files to ensure that our documentation and tracking systems were accurate and that all files are accounted for.
    - **Number of boxes/files stored off site: 13,157 boxes/ 178,756 files**

5. Conducted outreach activities to communicate records management awareness to internal and external stakeholders:
    - Along with Communications organized the 150th anniversary celebrations which included exhibits for Doors Open, which had over 700 visitors, a history of the College for publication on the CPSO website and weekly Heritage Minutes published on the Intranet for staff.
    - Organized and attended the annual Records Management Special Interest group at the FMRAC 2016 Annual General Meeting.
    - Participated in the annual FHRCO annual records management meeting.
    - Held the 10th anniversary RMA Open House with a record attendance of 150 **staff**.

C. FACILITIES

Mission Statement
To be a partner to our stakeholders and deliver professional services including planning, operations, maintenance, infrastructure and stewardship that support core business programs in a well-maintained physical environment.

Vision Statement
To inspire trust with our partners through dedication to solution-focused planning, commitment to positive change/innovation and consistency of service and support.

Strategies for Facilities:

Provide a Safe Physical Working Environment
- Security staff monitor all people entering the building throughout the day. All guests and staff are required to wear ID badges while on the premises

and guests are escorted to and from meetings to ensure they leave by the appropriate exit.
- Security Services is engaged to support any threats against staff, guests, committee members and other professionals that work for the College.
- Update Security measures for Accounts Receivable – due to the changes surrounding the collection and storage of data in the payment card industry, security changes were defined for Finance/Mailroom. Additional measures were installed to ensure that the space is locked at all times and security devices were tied into on-site security.
- Environmental Management: Regular sampling of cooling tower and humidifier pans for legionella. This sampling takes place 3 times per year for the safety of staff and guests. As well, indoor air quality testing is conducted triennially.
- Meet requirements for Accessibility for Ontarians with Disabilities Act.

Mitigate Risk

- Continued to test emergency evacuation procedures and annual testing. Completed annual life safety testing required by code.
- Achieved the "Highly Protected Risk Award", in recognition of risk improvement and ongoing commitment to property loss prevention from our insurance company HIROC.

Key Performance Indicators

Maintenance

	2016
Work Orders	3,593
Average Time to Complete Work Orders	2.38 days
Excluding emergency work and capital projects, the Maintenance area responded to almost 3,600 work orders last year in various areas of building maintenance including, lighting, plumbing, mechanical, environmental controls, moves, custodial and equipment maintenance.	

Meeting and Events Services

	2015 YR	2016 YR
Meetings in Conference Rooms	3,201	3720
People Served in Conference Rooms	25,189	31,427
Notes: In 2016, there was an increase of 16.2% of on-site meetings and 25.6% increase in attendees compared to 2015. About 80% of meetings require some sort of A/V equipment.		

	2015 3Q +4Q	2016 3Q + 4Q	2016 YR
People Requiring Assistance at Security Services	6,826	8,302	12,195
Notes: in comparing the data collected for the above time periods, there is an increase of assistance provided by Security Services at the front desk of over 21% during the latter halves of 2015 and 2016. At a time when there is an increase in electronic information, there continues to be growth for in-person assistance required of the security services staff.			

Planned Capital Projects

- Improve seating in meeting rooms – the dining room and 3rd floor boardroom chairs were replaced due to wear and tear as well as responding to customer complaints. We were able to negotiate better pricing, which allowed staff to replace over 90 chairs under budget.
- Design and retrofit space on the 5th floor to accommodate 9 additional staff members – the I & R division determined that workflow would improve if staff members were not transferred to the off-site space. Facilities retrofitted the space on the 5th floor to increase work spaces, by slightly decreasing some cube sizes.
- Tendered an RFP to several firms to support the College in developing a workplace strategy to assist with the logistics of managing growth and space together in a longer-term solution. Deloitte was selected by a panel of senior staff.
- The College signed an updated lease agreement with 800 Bay, which decreased the monthly rent to the original pricing from 2013. This secured the off-site space for from 2017 to 2021 with further options.
- Completed heating and lighting controls upgrades for the last two floors in the building. This provides electronic control remotely for temperature

monitoring and programming. As all the sensors are now digital, there is improved control available

Keep property Clean and Well-Maintained

- Housekeeping and maintenance staff increased sanitation of "hand-touch points" throughout the building during the epidemic and flu season.
- All public areas are clean and well maintained. Snow removal annually to handle exterior challenges in winter. Potential hazards are identified by building staff or health and safety committee members and dealt with quickly.
- Interior parking garage is swept regularly and cleaned twice per year.
- Exterior property is swept and reviewed on regularly (i.e. daily/weekly)

Find Ways to Reduce Our Carbon Footprint

- HVAC system and lighting adjusts based on occupancy load and reduces energy outside regular business hours. New occupancy sensors are being introduced to control lighting more effectively in lower-use areas (i.e. storage and washrooms).

Accommodate Variety of On-Site Meetings

- There again is an increase in meetings and events that take place at the College. This has been an established trend for the last few years. As well, with the meetings getting larger, the Council Chamber has been purposed to accommodate larger meetings on-site, instead of being utilized for Council meetings and Discipline Hearings. As well, staff have developed business relationships with off-site spaces available nearby in order to meet demands.
- Meetings included: business meetings, interviews, committee meetings, council meetings, discipline hearings, FHRCO events and other external groups.

Public & Physicians

- Continued to manage high profile hearings, which require additional staffing and security screening protocols.
- Continued cross-departmental training with departments that directly support the public and physicians to handle many inquiries immediately in the lobby.

D. Finance and Business Services

Finance Department

The underlying purpose of the Finance Department is to provide financial information that is needed by management to help them plan and monitor the activities of the College.

Business Services

The Business Services Area exists to support the College with coping, scanning and binding requests.

Finance

- Annual external audit was completed and it was a clean audit
- Budget for 2017 was approved by Council
- Continued our core functions – Accounts Payable, Accounts Receivable, Payroll and Financial reporting
- Pension Administration

Business Services

- Continued with our core functions – photocopying, scanning, binding and electronic generation of agendas and committee material

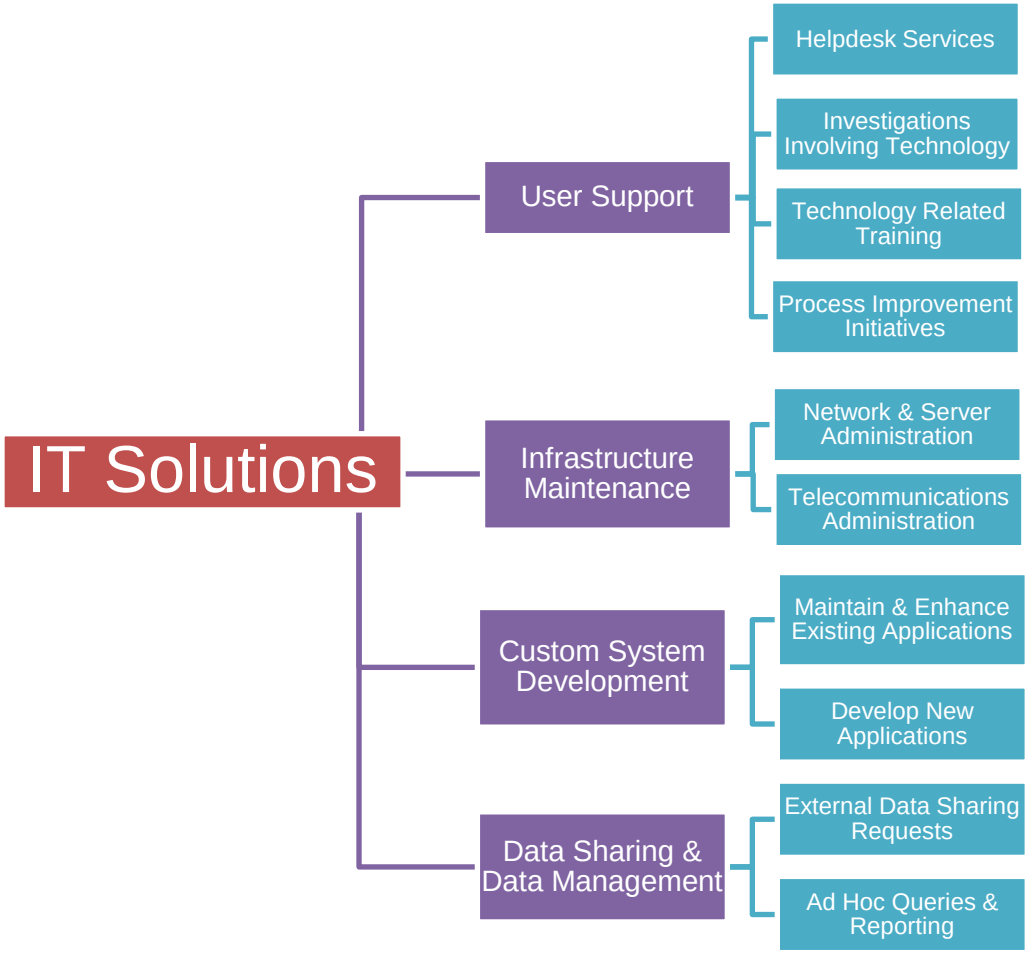
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2016 DIVISIONAL REPORT

Information Technology Solutions

Information Technology Solutions
2016 Departmental Report

WHAT WE DO



The IT Team offers a wide range of services that establish, manage, secure and support the technology and communications infrastructure (networks, PCs, phones) and systems used to support the business of the College. More information on these services are as follows:

- **User support** – Through the Helpdesk we manage immediate technology and telecommunication issues, assist in the acquisition and installation of new software and equipment and manage system access rights. We also develop and provide training and information related to technology and its use to support business processes.
- **Custom system development and Process Improvement**– We create new custom systems, maintain and enhance existing systems and partner with external consultants to deliver technology tools designed to support and improve business processes. Larger development projects are prioritized based on direction of the IT Steering Committee.
- **Data Sharing and Data Management** – We co-ordinate the Data Sharing Request and Approval process for all external requests for data and respond to internal requests for queries and reports relating to the data captured in our College systems.

- **Infrastructure Management** – We implement and maintain the CPSO technology infrastructure that provides various services: email, secure file transfer, file access and storage, backup, phone and telecommunication, Internet, IT Security, Wi-Fi, remote and network access, copying, and scanning. We make sure that our infrastructure is secure and performing as expected by installing regular software and security updates and monitoring for issues.

OUR STRATEGY

Our strategy for 2016 was based on four key assumptions:

1. Technology will evolve – we need to keep up to date and consistently re-invest so that we do not fall behind
2. We standardize on a Microsoft platform – not because it is the best, but because it is supportable and mainstream – we will always be able to find resources that are familiar with it
3. Our project priorities are set by the IT Steering Committee – based on the overall strategic and operational priorities of the organization
4. Where necessary, and in areas where we are lacking expertise, we will bring in experts to work with us.

We support the College's strategic and operating plan by:

- Improving and maintaining infrastructure
- Standardizing equipment and software where possible
- Ensuring that appropriate security and data protection is in place
- Developing, enhancing, and supporting enterprise or program-specific systems

Our process for prioritizing new projects involves input from College functional areas.

All College departments are represented on the IT Steering Committee. The Committee meets monthly to ensure that:

- IT strategy is aligned with the strategic and business goals of the College
- There is full participation by functional areas of the College in decisions about major IT projects and their potential impact on operational processes
- IT project decisions are regularly reviewed, monitored, prioritized and approved

SUPPORT

We offer a variety of support services. Helpdesk, the "first line" of support, is the most widely used. Requests for problem resolution or services are submitted online, by phone or email. We also provide support to users of technology tools in various ways; by developing and providing customized in-house training and guides for processes and applications. We also provide assistance in process improvement techniques, along with support for investigations using electronic records.

Helpdesk

Helpdesk is committed to ensuring that its stakeholders, both internal and external to the College, are provided with efficient and effective support.

In 2016, we had a total of ***4294 Helpdesk requests*** of which ***4180*** were closed—a 97% closure rate. Over the year, the team managed a workload that closed an average of 345 tickets every month. The types of requests are described below:

1) *Technical Services*
    - Access/Security/Set-up
    - Equipment Bookings
    - Installing a New Software Application
    - New Computer Requirements
    - New Hires & Departures – computer and telephone requirements

2) *Technical Problems & Incidents*

    - Folder Access Problem
    - Application Not Working Properly
    - Blackberry Problem
    - Desktop or Laptop Problem
    - Information/Data Change Request
    - Printer/Scanner/Copier Problem
    - Restoring Files Or Mailbox

3) *Training*

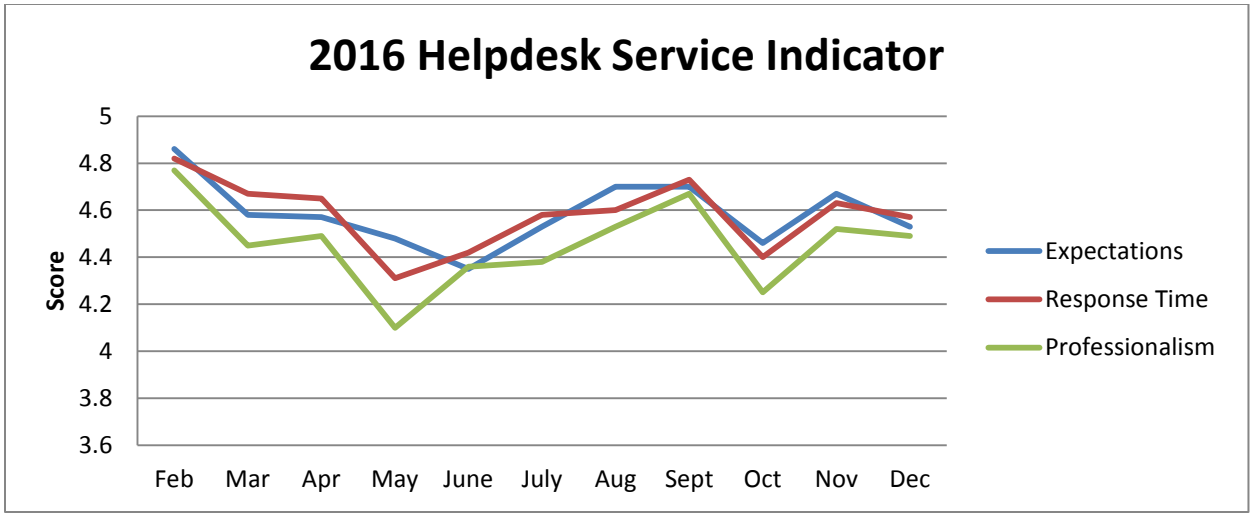
    - CPSO Custom Applications
    - Other CPSO Training
    - Windows/Office Applications

Customer Service

Good customer service is extremely important – we measure our success through an indicator calculated based on responses to a survey presented upon resolution of a Helpdesk request. The survey asks respondents to rank (on a 5 point scale where 5 is most positive) their experience relating to three aspects of service:

1. *Meeting Expectations* -“The request resolution met my expectations”
2. *Appropriate Response Time* -“My request completed in a timely manner”
3. *Professionalism* -“I was kept up to date on what was happening”

Below are the results of our 2016 Helpdesk Survey:



Overall, for 2016 we had high scores in all of the components of our Customer Service Indicator; scoring an aggregate expectations average of 4.6, a response time average of 4.6, and a professionalism average of 4.5. Our goal for 2017 is to increase our ratings to 4.8 in an effort for continuous improvement to be aligned with our strategic priorities for 2017.

Interesting Security Facts:

Our Web Filtering appliance blocked over 205,000 malicious Web addresses in 2016

Our Email Gateway allowed over 1,600,000 external emails to be delivered to and from CPSO in 2016 while blocking more than 180,000 that were deemed spam and malicious

Our Anti-Virus software has blocked more than 3,620,000 threat events on our PCs while catching and deleting 460 viruses

Hardware Support - By the Numbers:

We manage and support:

- 411 Desktop PCs
- 271 Laptops
- 148 Blackberries
- 55 Printers

- 507 Telephones
- 15 Physical and 117 Virtual servers
- 10 B&W and 2 Colour Canon scanners/copiers
- 13 Projectors
- 2 Office locations, 80 College and 800 Bay
- 570 Users

APPLICATION DEVELOPMENT- IT PROJECTS

Our Applications Development group builds and maintains custom software applications. We often work with external partners who bring specific technical expertise to our project teams. The projects we work on are prioritized by the IT Steering Committee, ensuring that our efforts are aligned to the strategic and operational needs of the College. Much of the work that we do stems from, and is in support of, process Improvement initiatives.

Below is a listing of the projects we successfully completed in 2016…

- AMS - Compliance Monitoring - Phase 2 CM& S Process Improvements
- Annual Renewal 2016
- Auditor's Reports
- Compliance Monitoring - Annual Report
- Every Physician Every 10 years (EPEX) Data
- Web Content Management system upgrade– Kentico 7.0 to Kentico 9.2
- Forecast Query for Peer Assessments 2017 - 2019
- I&R - Changing detail entries for CATS
- I&R - New Detail entries for CATS
- Maintenance and Infrastructure - Batch Servers O/S upgrade
- Maintenance and Infrastructure - DMS database separation
- Maintenance and Infrastructure - SQL Server Upgrade
- PA&E Business & Technology Improvements - Phase 1
- Physicians Apply Process Mapping
- Scotiabank Changes to Positive Pay File for Cheque Reconciliation
- Member Portal – Self-service features for practice info
- Secure Email and File Transfer - Implementation
- T4As
- Wordpress Consultation Page template enhancements
- Replace photocopiers
- Replace Desktop PC Hardware (300+)
- Replace 79 Committee laptops

DATA SHARING & DATA MANAGEMENT

In addition to supporting internal requests for information, we accept requests from external groups, wanting to use our data for a variety of purposes. Data is available on a "one-time" basis, annually or quarterly for a fee that covers our costs. Once a request is submitted, it is assessed by the Data Sharing Working Group (DSWG) – an internal committee. Requests are reviewed using a decision framework that incorporates a risk and resource impact assessment and also considers whether the use of the data relates to the Objects of the College. IT manages the relationship with the requestor, facilitating the request process through the working group, communicating with the stakeholders of this process, and ultimately fulfilling approved requests.

External Data Sharing Requests:

In 2016, we received a total of 87 new requests, of which 62 were reviewed by the Data Sharing Working Group. There were 25 requests did not proceed to the Data Sharing Group as they were either withdrawn by the requestor or were clearly commercial.

The majority of our requests for data sharing in 2016 came from health care providers and by hospitals.

Ad Hoc Queries & Reporting:

We regularly receive requests from program areas of the College to provide information that are used to help inform decision making, and provide context in presentations or reporting. In 2016 we fulfilled over 49 requests for Queries and Reports.

LOOKING FORWARD for IT SOLUTIONS….

A preview of 2017 projects…

- AMS - PA&E Business & Technology Improvements - Phase 2
- Annual Renewal and Post Grad Renewal 2017
- Auditor's Reports
- Blackberry Replacement
- Replacement of I&R Case Tracking system (CATS)
- Refresh IT Strategy
- Member Dashboard - Generic Payment
- Auto-expire for Post Grads
- National Application for Medical Registration
- Security and Privacy Awareness program
- PCI Compliance
- Server Infrastructure Replacement
- SharePoint -Phase 1: ICRC Committees
- SharePoint – Phase 2: (Other Committees etc)
- Solomon Financial system upgrade
- Support for Data & Analytics Strategy
- T4As
- Transparency - Retrospective analysis of processes

- Website: New Homepage, Navigation, Improved Page Displays, Responsive Site
- Website: Public Register Improvements to Search & Display Details
- Website: authenticate and redirect to eHealth OneID
- Windows 10 and Office 2016 upgrade

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2016 DIVISIONAL REPORT

Investigations, Resolutions, Hearings, Compliance Monitoring and Supervision Division

TABLE OF CONTENTS

Mandate

- Support the College's efforts to enhance quality of medical care and ensure patient safety.
- Conduct comprehensive and timely investigations and hearings.
- Monitor compliance with Orders, Undertakings, and Specified Education and Remediation Programs.
- Compile and analyze aggregate case data about care, conduct, capacity, and system delivery issues.
- Provide information to the profession to assist in minimizing complaints.

Structure

- An Intake/Triage area that assesses all member-specific information, streams cases, and directs specific investigative action. The area also follows up on positive responses to the questions on the annual renewal form, which include jurisdictional issues, civil litigation issues, criminal charges, and members' status regarding blood-borne pathogens if they perform exposure-prone procedures.
- Four specialized investigation teams.
- A Committee Support area that provides administrative assistance to the Inquiries, Complaints and Reports (ICR) Committee and supports the Committee in its case review and quality assurance activities.
- A Hearings Office that supports the two adjudication committees: Discipline and Fitness to Practise. The Office also prepares notices of suspension, revocation and restrictions.
- A central Compliance Monitoring and Supervision unit to ensure members fulfill agreements, undertakings, Orders and remediation programs required by College committees, including: the ICR, the Discipline, the Fitness to Practise, the Quality Assurance, and the Registration Committees.
- A statistical unit conducts in-depth analyses of closed investigative files to identify and assess factors that were influential in the outcome of investigations. Extracted information is entered into a central database that contains more than 400 unique coding factors. The analysis of these data identifies trends in physician practices and guides policy initiatives.

Strategic Priorities

The Division's work supports Council's Strategic Priorities by optimizing the fairness, effectiveness and efficiency of the Investigations, Discipline and Monitoring Processes. The Division's objective is to reduce risk, support physicians to enhance their knowledge and skills, and improve health care.

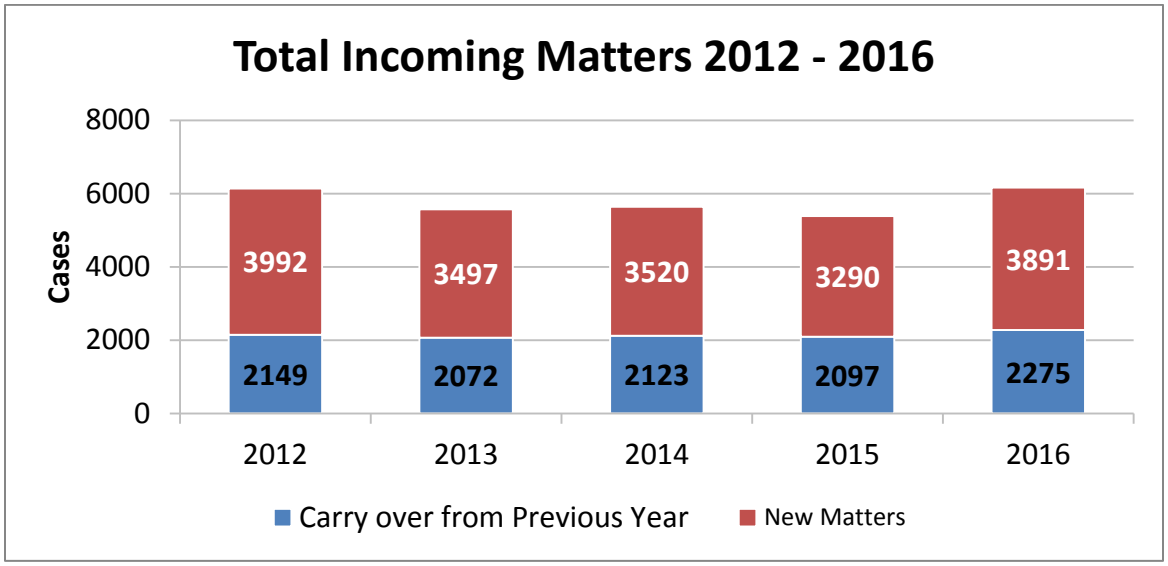
Investigations and ICR Committee Support Areas

The ICR Committee oversees all investigations into physician care, conduct, and capacity. The Committee oversees Public Complaint Investigations, broader practice (Registrar's) Investigations, and inquiries into a member's capacity.

Registrar's Investigations and Incapacity Investigations remain small in number proportionate to Public Complaints. They are, however, often more intricate than most patient-related complaints, which require looking at the patient's record and relevant information related to the patient (complainant's) concerns. Registrar's Investigations include review of 25 patient charts by an external assessor, interviews, and often observation. Incapacity Investigations include various types of external health assessments, interviews, and review of records.

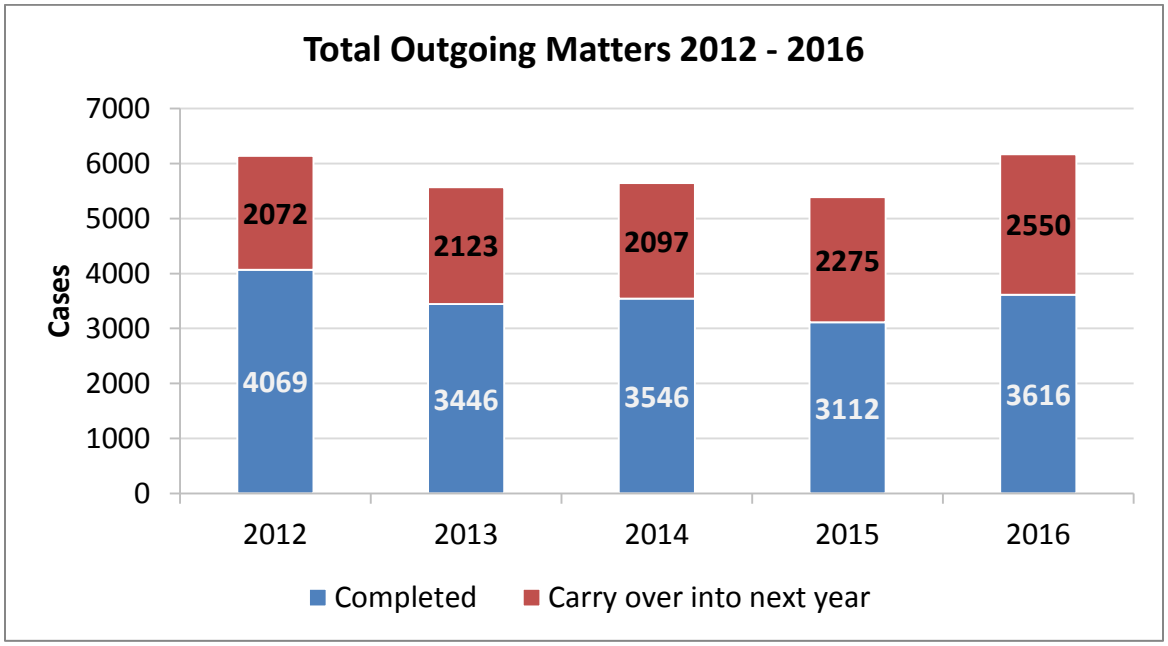
Certain investigations can be particularly complex. Investigations into sexual misconduct are typically very detailed and require extensive investigator resources, given the mandatory revocation penalty if these allegations are proven at a discipline hearing. Witnesses must be interviewed. If concurrent criminal charges have been filed or if the police have investigated, records must be obtained from the Crown and the courts.

Caseload



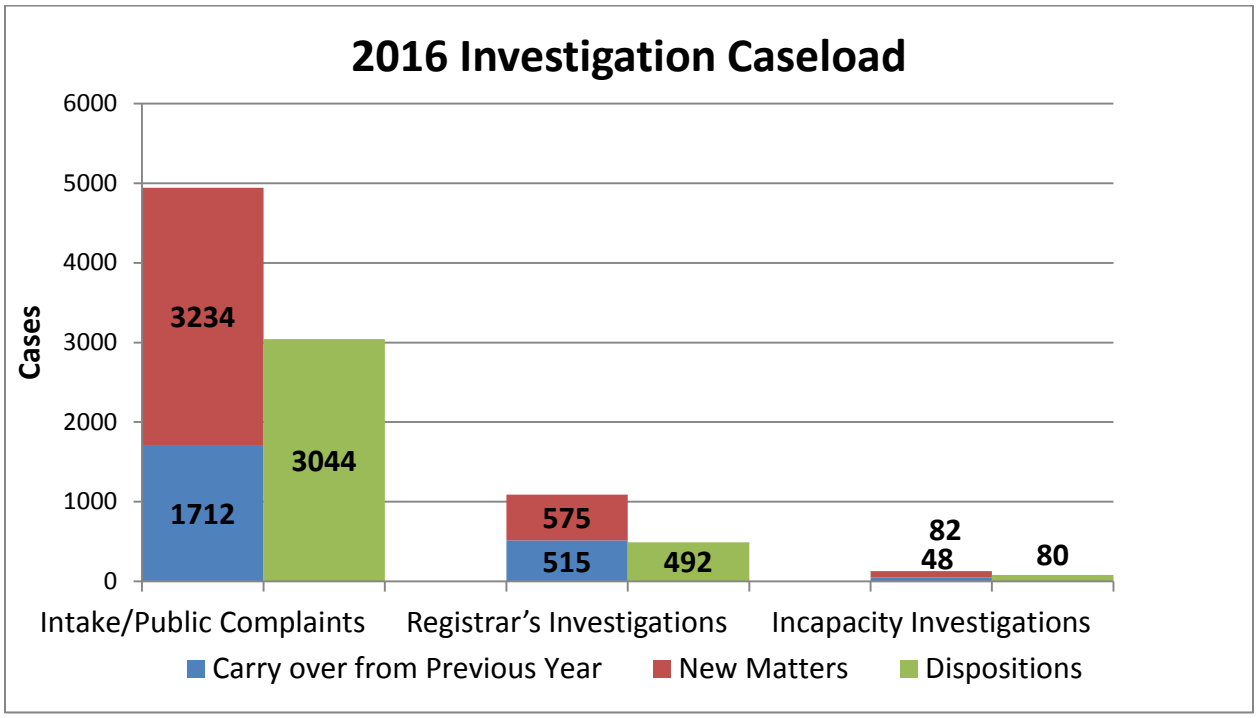
As of December 31st, 2016

*New Investigations increased by 18% as compared to 2015



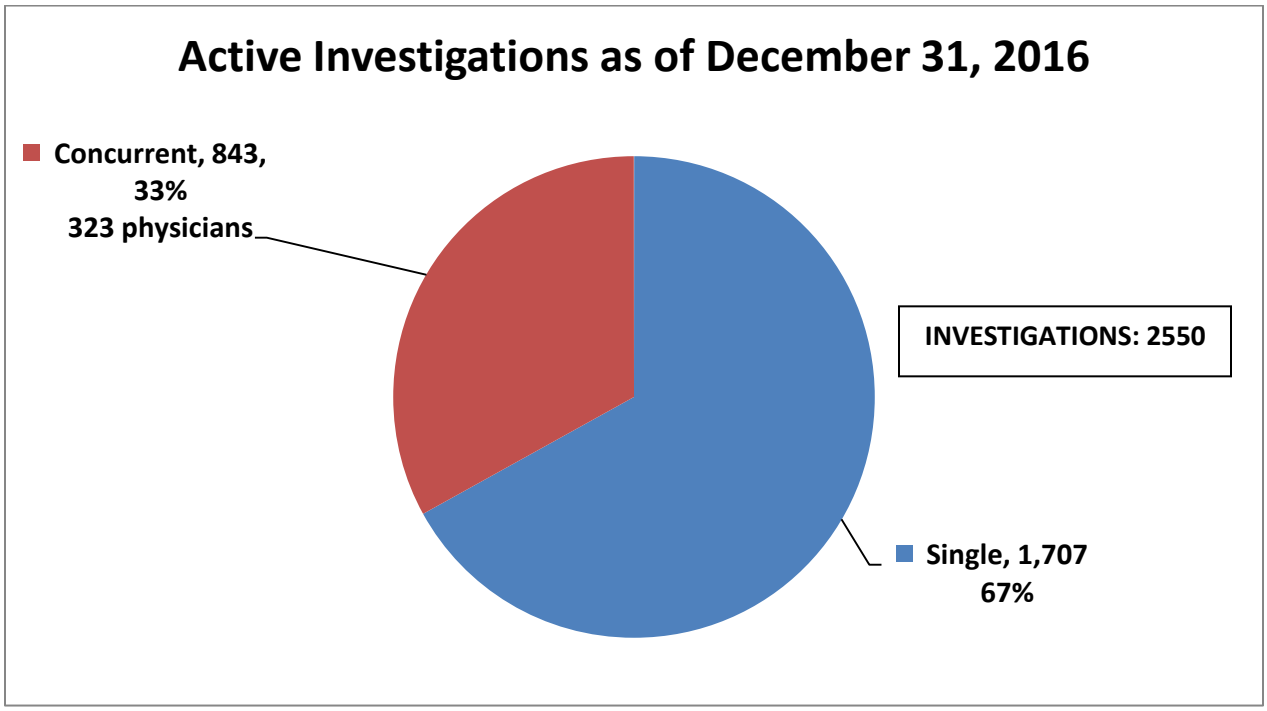
As of December 31st, 2016

*Completed investigations increased by 16% as compared to 2015



Carry over from previous year as of December 31st, 2016

- New Intake matters increased by 26% (549).
- New Public Complaint Investigations increased by 12% (2,685). Sixty-two percent of Public Complaint investigations (new and carryover from 2015) were disposed.
- New Registrar's Investigations increased by 53% (575). Forty-five percent of Registrar's Investigations (new and carryover from 2015) were disposed.
- New Incapacity Investigations increased by 15% (82). Sixty-two percent of Incapacity Investigations (new and carryover from 2015) were disposed.



- As of December 31st, 2016, 33% of open investigations involved a physician with more than one active investigation.

Infection Control Investigations

Over the last year there has been significant work with the Ministry and Public Health Ontario to seek a consistent approach to Infection Prevention and Control (IPAC) investigations that are brought to the College's attention. Specifically, the Division receives IPAC referrals from various sources as listed below:

- within individual public complaints
- from Public Health Units (PHU)
- as part of a report of concern (i.e. Registrar's Investigation)
- through PAS, phone calls that indicate office/clinic hygiene concerns.

These concerns are investigated in collaboration with the associated Public Health Unit when appropriate, using tools developed by Public Health Ontario.

Prescribing Investigations

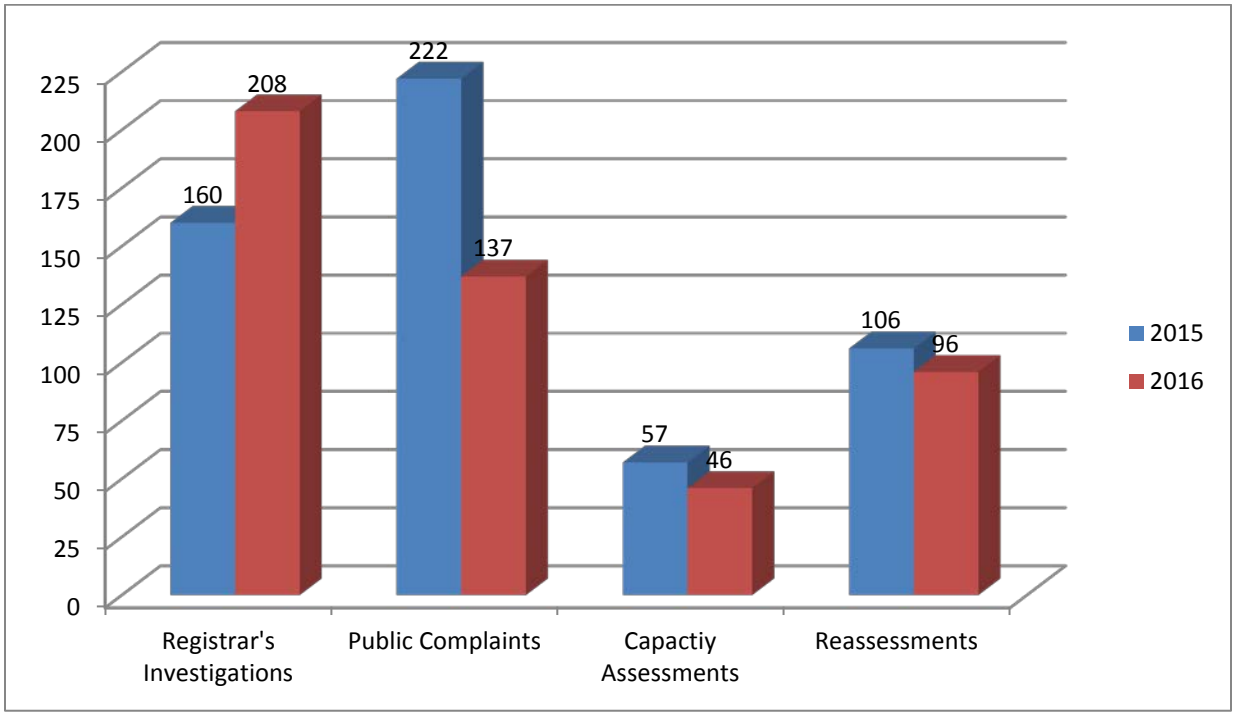
The Division has initiated a large number of clinical investigations into opioid prescribing as a result of information received from the Narcotics Monitoring System. These investigations may identify risk of

harm to patients of continued prescribing in some circumstances. However, there is also a risk of harm to patients of discontinuing prescribing. In order to balance these risks, the goal of investigations will be to support continued prescribing under close supervision where remediation is possible.

Assessors

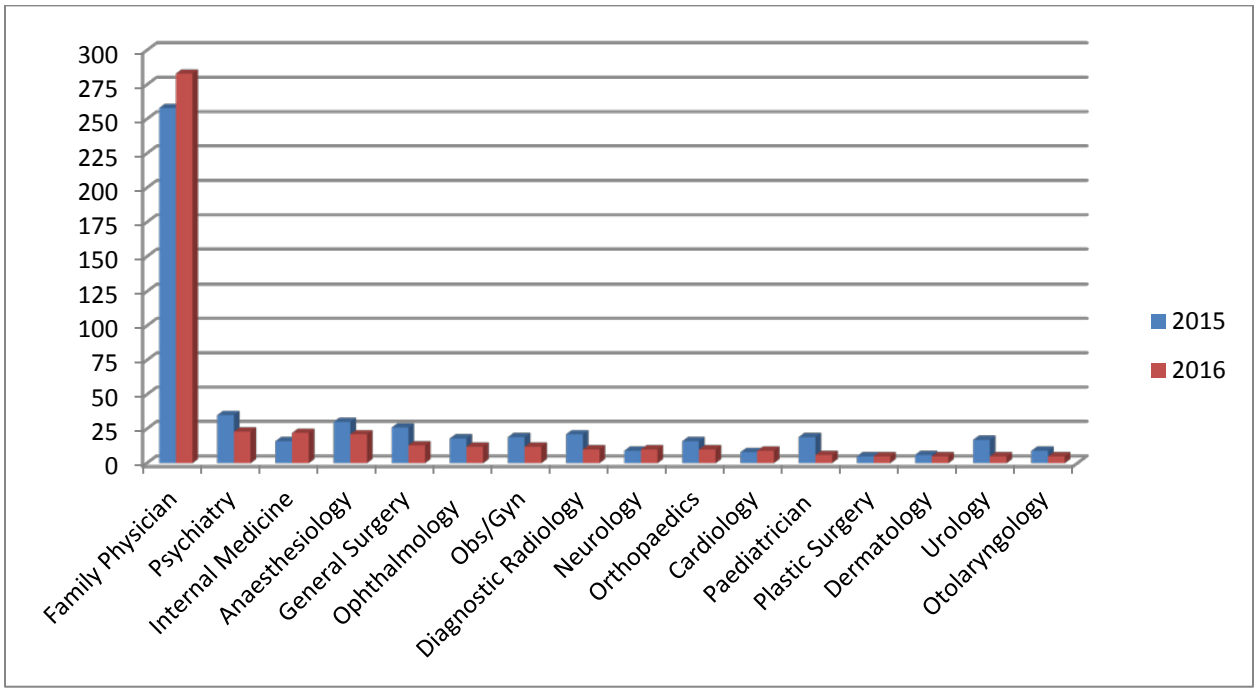
Assessors were retained in 487 matters at the College in 2016, 105 of the Assessors being new. Training of new (and existing) Assessors has been enhanced and 12 in-person training sessions were conducted in 2016.

Assessor Requests by Type – 2015 and 2016 Comparison



- The jump in number of RIs was primarily related to prescribing cases.
- The drop in number of IOs (independent opinions) was primarily related to the decrease in the number of Pre-ICRC IOs.
- Family Physicians and General Practitioners continue to represent the specialty with the greatest number of Assessor requests. 58% of all Assessor requests in 2016 were for matters involving FPs /GPs.
- No other specialty made up more than 5% of Assessor requests, with Psychiatry being second at 4.7%.

Specialty



Assessor Challenges

There continued to be some difficulty in finding assessors for particular areas of practice, including Complementary Medicine, Narcotic Prescribing, Chronic Pain and Bio-identical Hormone Replacement.

Committee Support

Number of Meetings

A large component of Committee Support's work continues to be coordinating all aspects of ICR Committee meetings.

Type of Panel	2012	2013	2014	2015	2016
General Panels	20	20	20	24	24
Teleconferences	36	36	36	40	40
Specialty Panels (includes Surgical, Family Practice, Mental Health, Obstetrics and Internal Medicine)	50	51	51	50	50
Health Inquiry Panels	22	22	24	24	24
Fast Track	24	24	24	24	24
Medium Track	0	12	12	12	12
Ad Hoc Meetings	24	24	24	24	30
Cautions in person	24	24	49	50	50
Settlement Panels	-	-	-	2	18
Narcotics Monitoring System (NMS) – New Ad-Hocs in 2017	-	-	-	-	-
Total Number of Panels Struck	**200**	**213**	**240**	**250**	**272**

Matters Considered and Decisions Issued

YEAR	MSI Considered	MSI TRENDS	Decisions Issued	Decision TRENDS
2012	3871	—	2696	—
2013	3652	↓ 6%	2435	↓10%
2014	4206	↑ 15%	2660	↑9%
2015	3809	↓ 10%	2527	↓5%
2016	4298	↑ 13%	2765	↑9%

MSI = Total of all Member Specific Matters that went before all ICRC panels and includes cautions administered
Decisions = Written Decision and Reason

Matters considered by Specific ICR Committee (ICRC) Panels

Meetings	2012	2013	2014	2015	2016
ICRC General Panels	1377	1141	1302	1189	1179
ICRC Teleconferences	675	704	1056	957	886
ICRC Specialty Panels	1166	1339	1242	1032	1245
ICRC Health Inquiry	108	94	125	98	132
ICRC CiPs Administered*	143	103	124	124	116
ICRC Fast Tracks	395	270	217	229	338
ICRC Medium Tracks	n/a	n/a	137	173	318
Exec MSI matters	7	1	3	-	-
Settlement Panels	-	-	-	7	84
Total	**3871**	**3652**	**4206**	**3809**	**4298**

Public Summaries

The ICR Committee continues to use its Risk Framework in forming its decisions. Committee Support continues to write case summaries for the public register for caution-in-person and specified continuing education or remediation program ("SCERP") outcomes. Responsibility for Public Summaries has increased the public nature of Committee Support's work.

June 1, 2015 – December 31, 2016

	Published on the CPSO Register	Appealed
Caution in Person disposition	92	18 (33%)
SCERP disposition	66	27 (49%)
Caution in Person and SCERP dispositions	29	10 (18%)
TOTAL:	**187**	**55 (29%)**

Remedial Agreements

Under the transparency initiative, the ICRC directs Remedial Agreements (RAs) in low risk cases where minor educational needs are identified, and where the Committee would like confirmation (follow-up) that the physician has addressed those needs.

June 1, 2015 – December 31, 2016

	RAs Directed	RAs Signed	RAs Decline to Sign	RAs In process to be signed
TOTAL	**194***	**187** **(96%)**	**6** **(3%)**	**0** **(0%)**

**1 file was relisted to another panel*

23 RAs overall have been appealed to date which represents 12% overall.

Settlement Panels

On November 11, 2015, the ICR Committee commenced settlement panel meetings, managed by Committee Support. Settlement Panels meet twice a month for 2 hours and additional ad-hoc meetings are booked as needed to deal with high-risk cases promptly.

November 1, 2015 – December 31, 2016

	Settlement Panel Meetings	Cases
2015	2	7
2016	18	84
Total	**20**	**91**

To date Committee support has facilitated 26 settlement panel meetings that have dealt with 91 matters.

Independent Opinion (IO) Checklist

In 2016, the ICR Committee introduced a guide to assist it in deciding when to request IOs in public complaint investigations, with an eye to improving the usage of IOs.

Decision Release Timelines

The ICR C set a benchmark for decision release at 8-12 weeks. Decision release times for the first part of 2016 were within this timeline. During the second half of 2016, decision release timelines increased to 12-15 weeks. A number of factors have increased the of Committee's workload in drafting, approval, and releasing of its decisions. These factors include:

- Increase in number of ICRC meetings per year and number of matters considered
- Increase in number of ICRC decisions
- Implementation of Transparency Initiative, requiring public summaries for certain ICRC decisions
- Staff turnover

Toward the end of 2016, Committee Support began actively reviewing processes and other factors to identify strategies which could reduce decision release timelines.

Real-time Evaluation of the Complaints Process and Decisions

In August 2016, the Division launched a real-time feedback survey. Parties (complainants and physicians for Public Complaint files) are invited to visit a separate web portal created by Environics Research to complete a confidential survey in two phases:

Phase 1 - satisfaction with investigation (end of investigation pre-decision) explores:

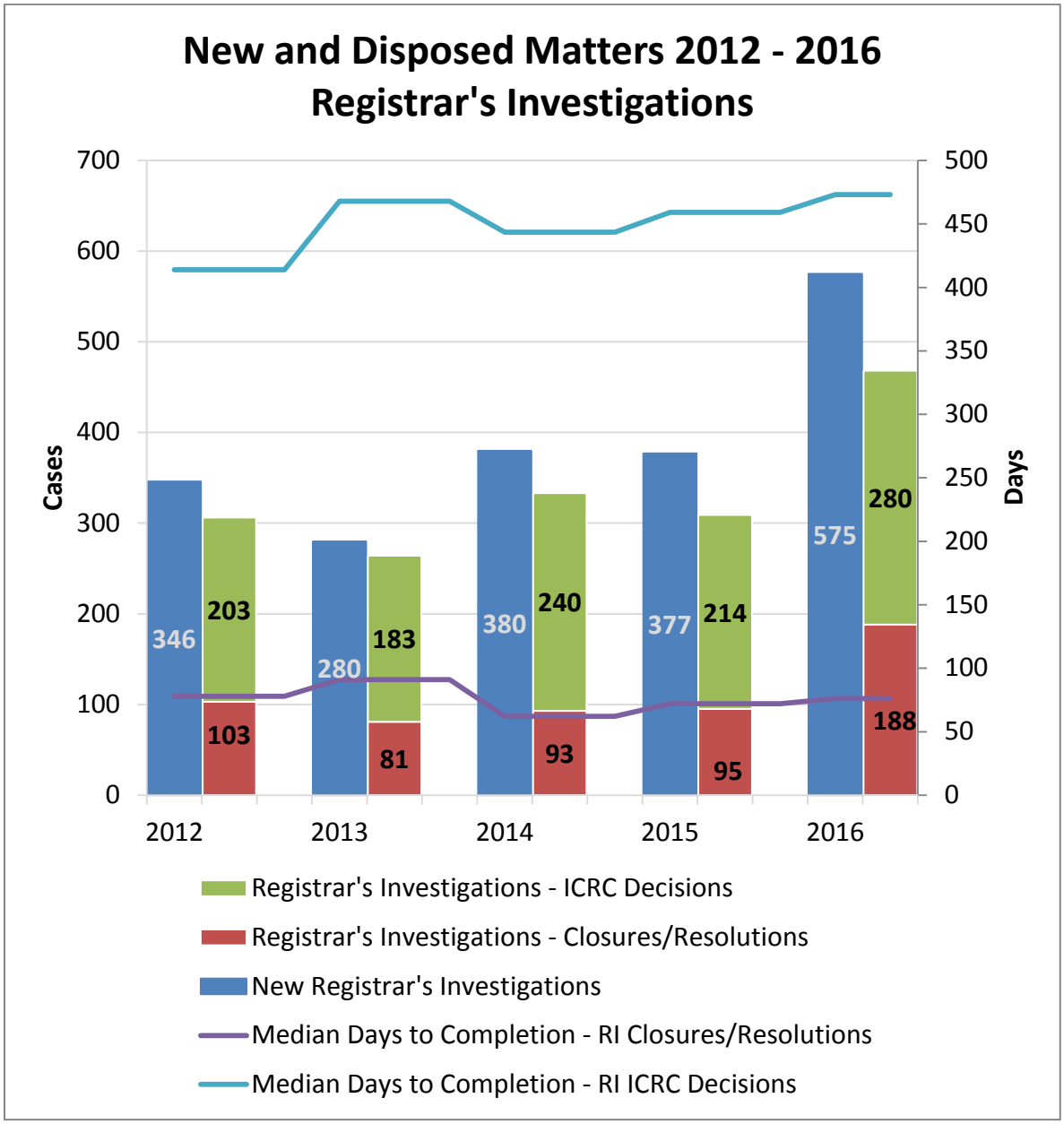
- Speed of process
- Objectivity/neutrality of investigator
- Investigator's ability to understand the issues and concerns
- Degree to which the parties were kept informed about the investigation's progress
- Whether the complainants felt their complaint was taken seriously

Phase 2 - satisfaction with the decision (post-receipt of decision) explores:

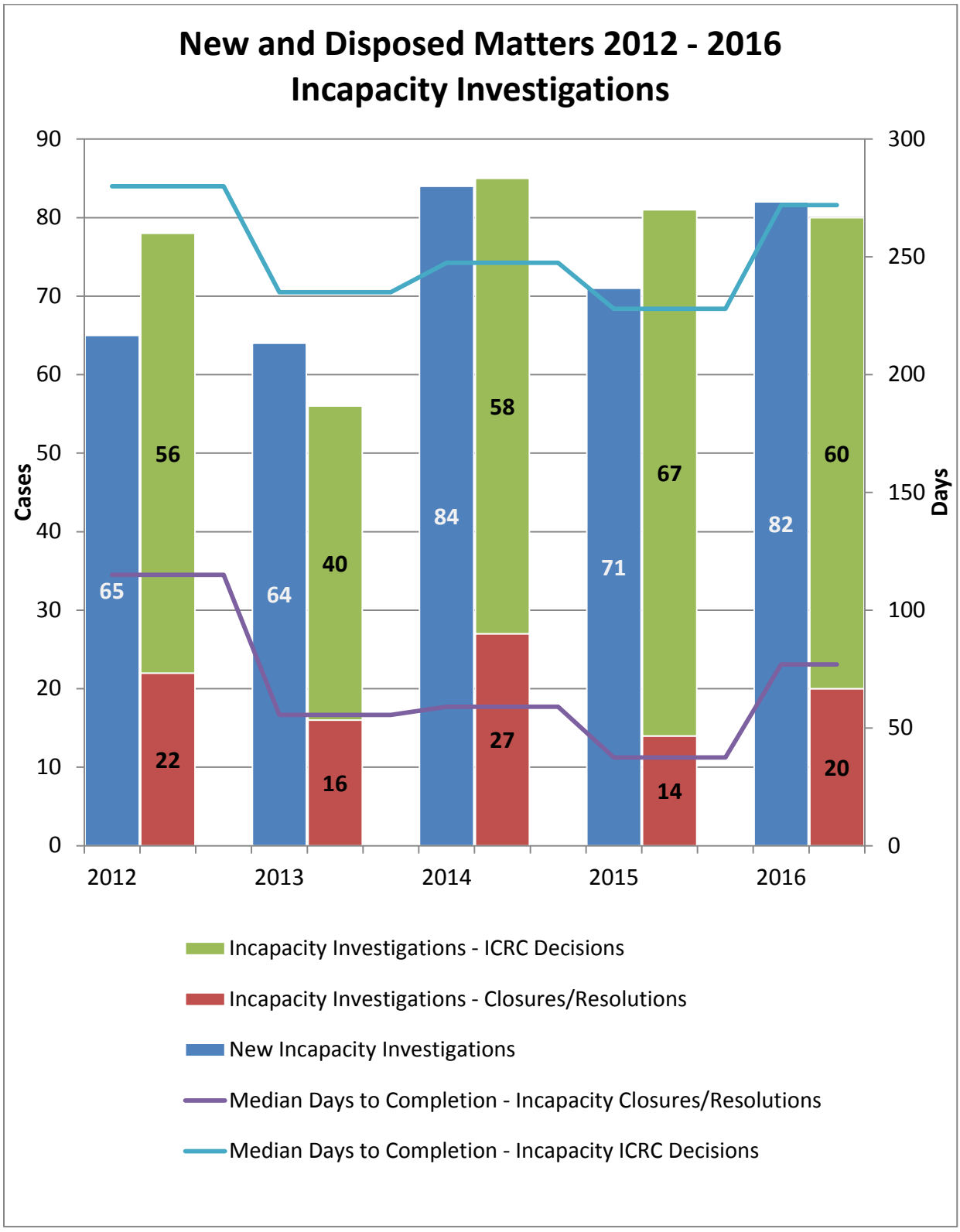
- Whether the decision provides clear reasons for the decision

Results and feedback will be anonymous and Environics Research will provide aggregate data and trends to the College on an ongoing basis.

Investigation and ICR Committee Statistics



As of December 31st, 2016



As of December31st, 2016

Public Complaints - ICRC Decisions 2012 - 2016

	2012		2013		2014		2015		2016	
	N	%	N	%	N		N		N	
ICRC: No Action	1941	80%	1322	60%	1530	65%	1365	61%	1563	65%
ICRC: Advice	119	5%	461	21%	421	18%	542	24%	515	21%
ICRC: Remedial Agreements							59	3%	107	4%
ICRC: Caution in Writing	190	8%	203	9%	202	9%	51	2%	1*	0%
ICRC: SCERP	57	2%	76	3%	73	3%	56	2%	76	3%
ICRC: Caution in Person	75	3%	88	4%	77	3%	76	3%	83	3%
ICRC: Undertaking	17	1%	10	0%	19	1%	13	1%	16	1%
ICRC: Referred to Discipline Committee	38	2%	52	2%	37	2%	81	4%	58	2%
ICRC: Referred for Incapacity Inquiries	-		-		1	0%	0	0%		0%
Total	**2437**	**100%**	**2212**	**100%**	**2359**	**100%**	**2243**	**100%**	**2419**	**100%**

As of December 31st 2016

**Caution in Writing decision is a HPARB return decision*

Registrar's Investigation ICRC Decisions 2012 - 2016

	2012		2013		2014		2015		2016	
	N	%	N	%	N	%	N	%	N	%
ICRC: No Action	69	34%	32	17%	57	24%	50	23%	78	28%
ICRC: Letter from Registrar	-	-	-	-	1	0%	0	0%	0	0%
ICRC: Advice	2	1%	15	8%	15	6%	21	10%	38	14%
ICRC: Remedial Agreements							5	2%	3	1%
ICRC: Caution in Writing	20	10%	22	12%	24	10%	7	3%	0	0%
ICRC: SCERP	32	16%	35	19%	33	14%	33	15%	31	11%
ICRC: Caution in Person	13	6%	8	4%	17	7%	15	7%	18	6%
ICRC: Undertaking	38	19%	46	25%	57	24%	51	24%	59	21%
ICRC: Referred to Discipline Committee	29	14%	25	14%	35	15%	32	15%	53	19%
Total	**203**	**100%**	**183**	**100%**	**239**	**100%**	**214**	**100%**	**280**	**100%**

As of December 31st, 2016

Monitoring RI Investigations

Decisions	2015	2016
Intake	1	18
ICRC: Advice		1
ICRC: Undertaking		1
ICRC: Referred to Discipline Committee	3	4
Total	**4**	**24**

As of December 31st, 2016

Incapacity Investigations ICRC Decisions 2012 - 2016

	2012		2013		2014		2015		2016	
	N	%	N	%	N	%	N	%	N	%
ICRC: No Action	22	39%	21	53%	21	36%	18	27%	11	18%
ICRC: Undertaking	30	54%	19	47%	33	57%	47	70%	42	70%
ICRC: Referred to incapacity inquiry	1	2%	-	-	-	-	0	0%	0	0%
ICRC: Referred to Fitness to Practice	3	5%	-	-	4	7%	2	3%	7	12%
Total	**52**	**93%**	**40**	**100%**	**54**	**100%**	**67**	**100%**	**60**	**100%**

As of December 31st, 2016

HPARB Appeals Based on 2014 - 2016 Decisions

Year	Appealable Decisions Issued	Decisions that were Appealed	Appealed decisions that indicate the source of the appeal	Appealed decisions that were appealed by the Complainant*	Appealed decisions that were appealed by the Subject Physician*	Total HPARB Reviews Received thus far	Total HPARB Decisions Upheld**
2014	2326	370 (16%)	92 (25%)	82 (89%)	10 (11%)	338 (91%)	307 (91%)
2015	2162	431 (20%)	431 (100%)	340 (79%)	91 (21%)	326 (76%)	295 (90%)
2016	2361	436 (18%)	436 (100%)	391 (90%)	45 (10%)	Too few received	Too few received

As of December 31st, 2016

*Only includes data for appealed decisions in which there is information relating to the source

**Only includes data for appealed decisions that were received

Hearings Office: Discipline and Fitness to Practise Committees

The Discipline Committee manages each case from the time of referral to decision. The Discipline Committee's goal is to eliminate unreasonable delay in the process and release clear and complete decisions, while meeting performance indicators.

The stages of the process regarding allegations of professional misconduct and incompetence are:

- Referral of specified allegations by the Inquiries, Complaints and Reports Committee
- College disclosure to the Member of relevant non-privileged information
- College and Member disclosure of documents and things they may seek to put forward in evidence, a list of witnesses, and a summary of the substance of the evidence
- Pre-hearing processes, including case management conferences and pre-hearing conferences
- Potential resolution resulting in withdrawal of all allegations or an uncontested hearing
- Hearing
- Written Decision and Reasons for Decision

Pre-Hearing Processes and Case Management

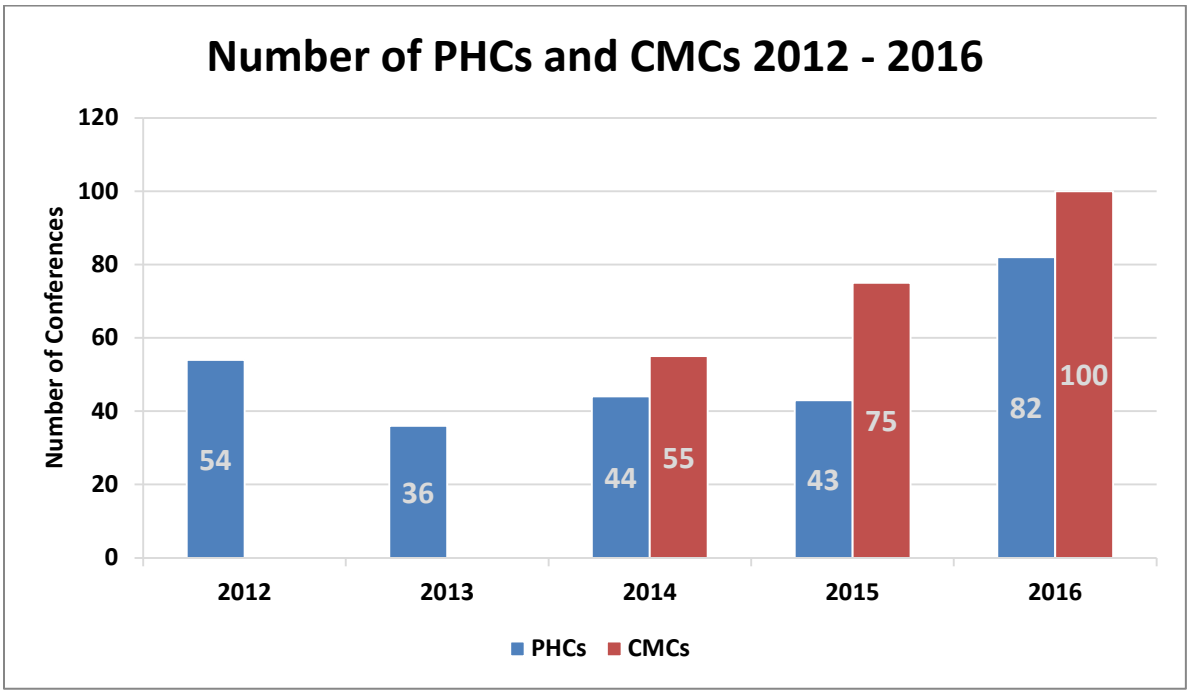
Pre-hearing conferences (PHCs) have both a case resolution function and a case management function. The purpose of the PHC is to determine:

- Whether any or all of the issues can be settled
- Whether the issues can be simplified or clarified
- Whether there are facts that can be agreed upon
- Whether further disclosure or pre-hearing motions are required
- The scheduling of motions and the hearing

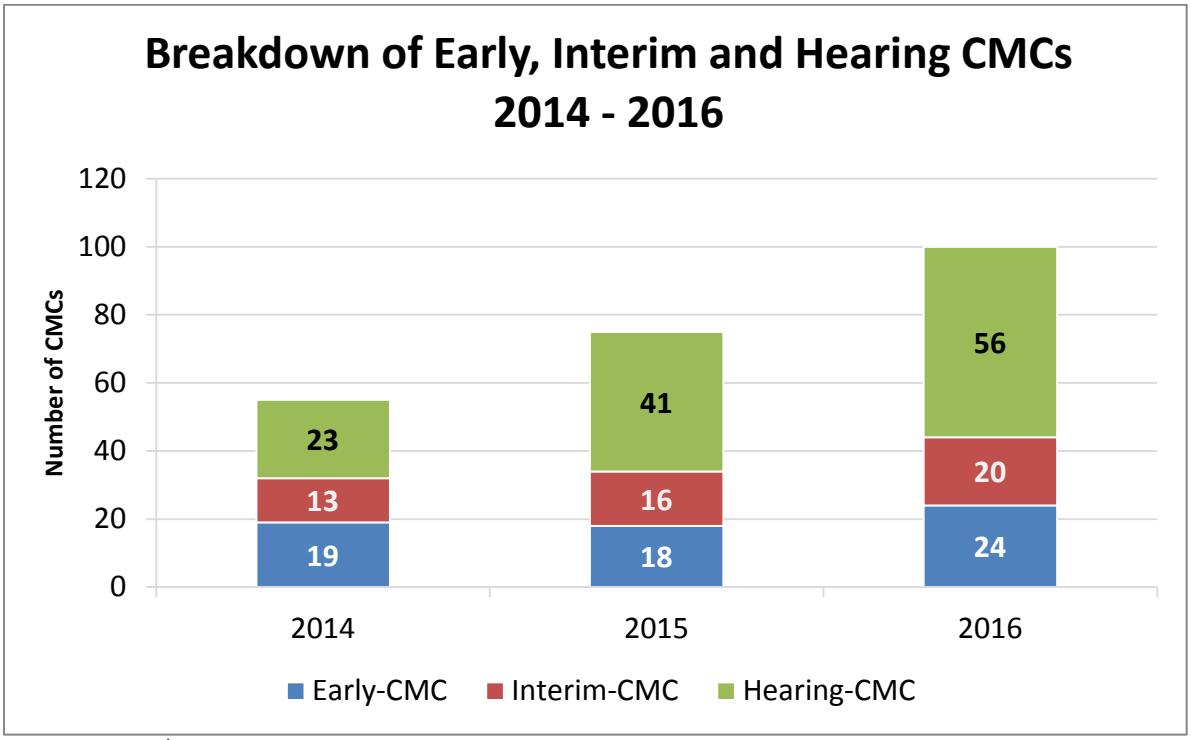
The Discipline Committee conducts Case Management Conferences (CMCs) to:

- facilitate scheduling of PHCs
- provide periodic oversight based on the needs of the case
- identify any new issues prior to a multiple-day hearing and ensure an adequate number of hearing days/efficient use of hearing time
- aid in scheduling penalty hearing dates

From 2012 to 2016, the Discipline Committee has more than doubled its case management activity.



As of December 31st, 2016



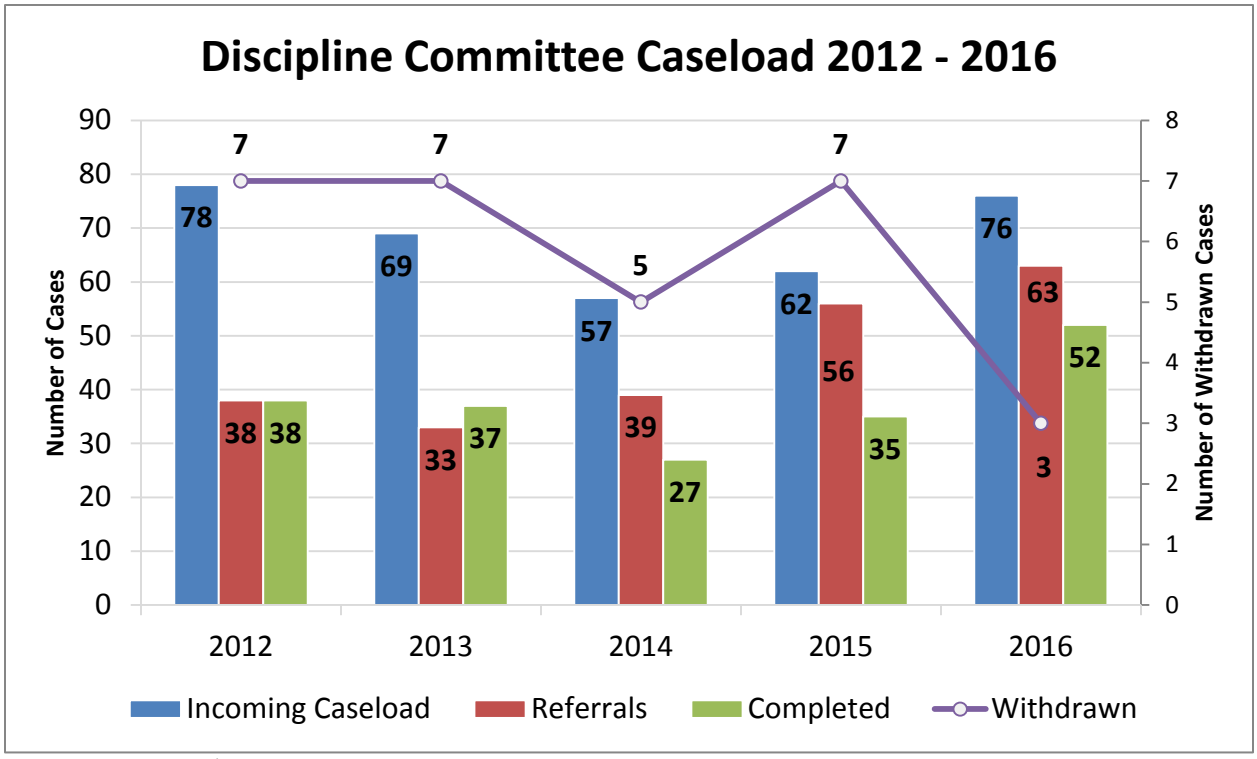
As of December 31st, 2016

Caseload – Referrals, Completed and Withdrawn Cases

The Discipline Committee's caseload is increasing. The caseload at the end of 2016 was 84 coming from 63 referrals in 2016 and 56 referrals in 2015, the highest received since 2009.

The Discipline Committee completed a record 52 cases in 2016.

In 2016, the College withdrew all allegations in three cases when the physicians signed an undertaking to resign and not reapply.



As of December 31st, 2016

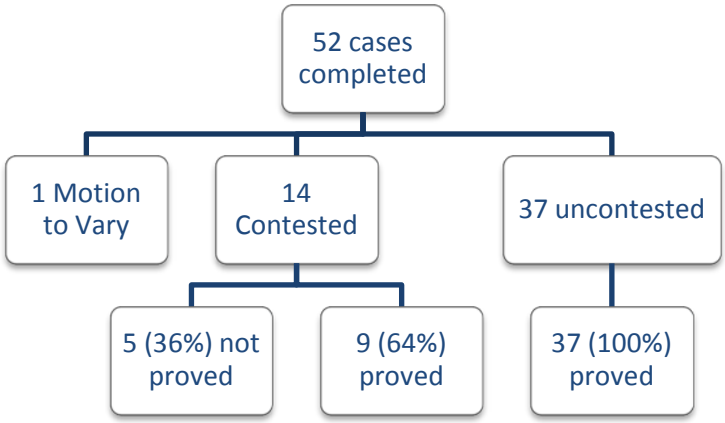
Note: in 2016, ICRC referred 115 cases to the Discipline Committee, involving 62 Notices of Hearings. The remaining referral was a Registrar's referral of an application for reinstatement.

Also, there were 2 cases in 2014, 1 case in 2013, and 2 cases in 2012 where the referral did not proceed because the subject physician had passed away.

Discipline Findings and Current Referrals

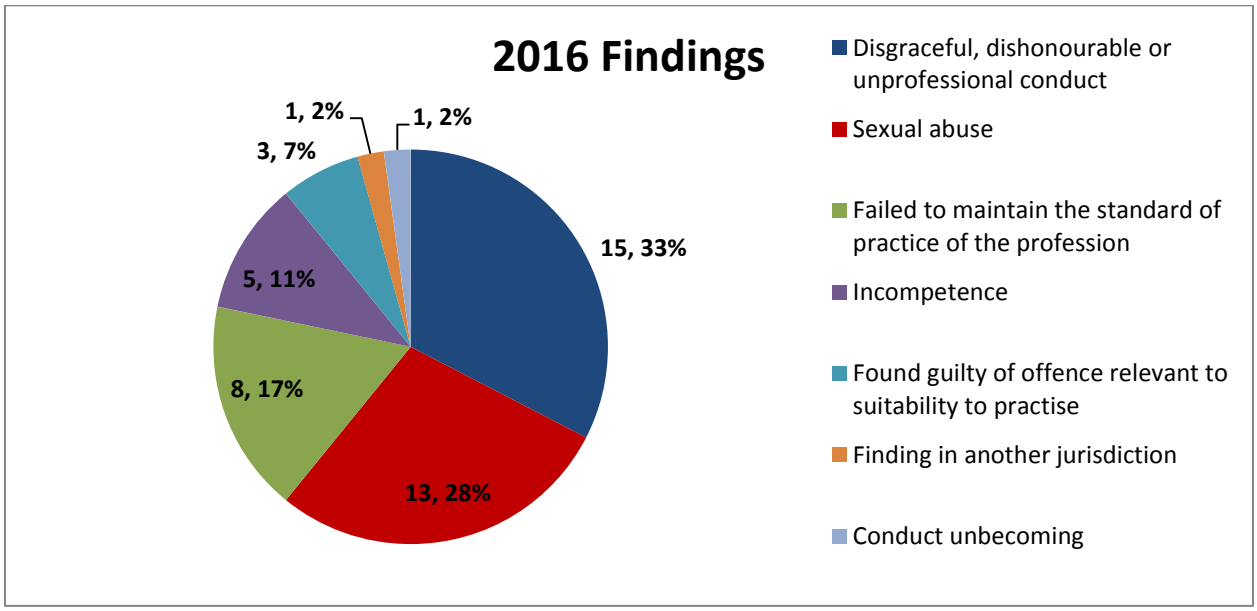
In 2016, the Discipline Committee completed 52 cases.

- 1 case was a motion to vary the terms of a prior order (granted); and
- 51 cases involved allegations of professional misconduct and /or incompetence, as follows:



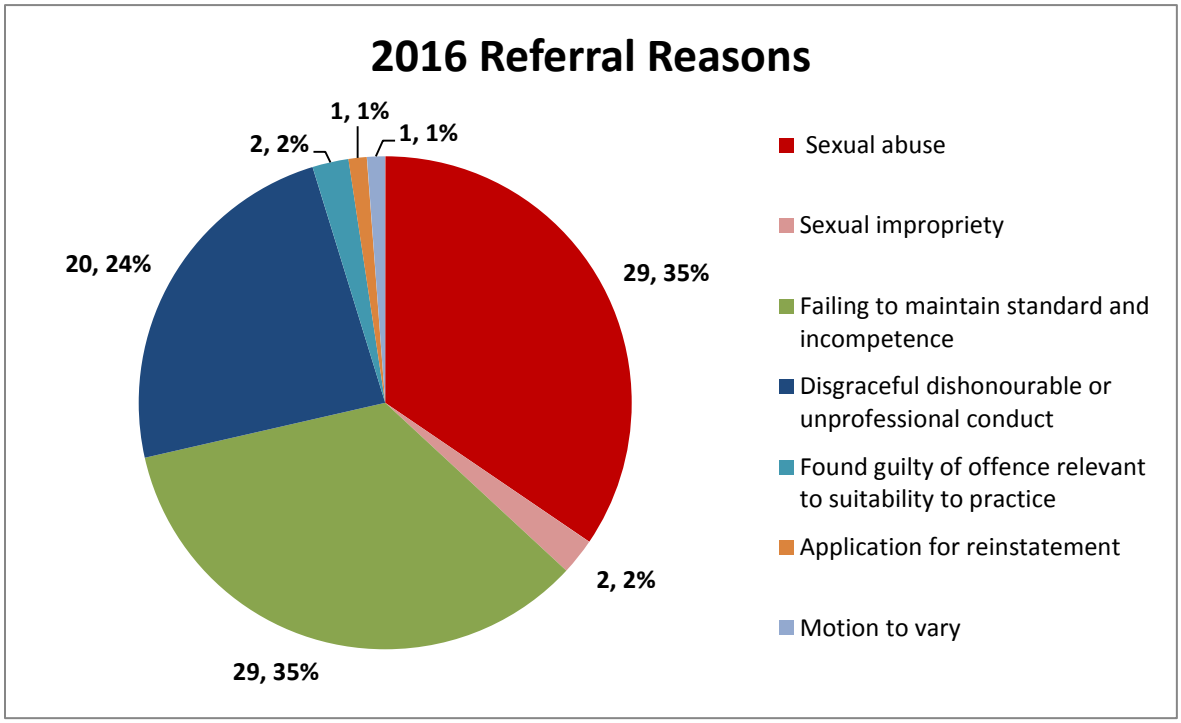
9 proved contested cases + 37 proved uncontested cases = 46 cases or 90% where some or all allegations were proved.

Findings of 46 Proved Cases:



Current Referrals

At the end of 2016, there were 84 cases before the Committee. Allegations were as follows:

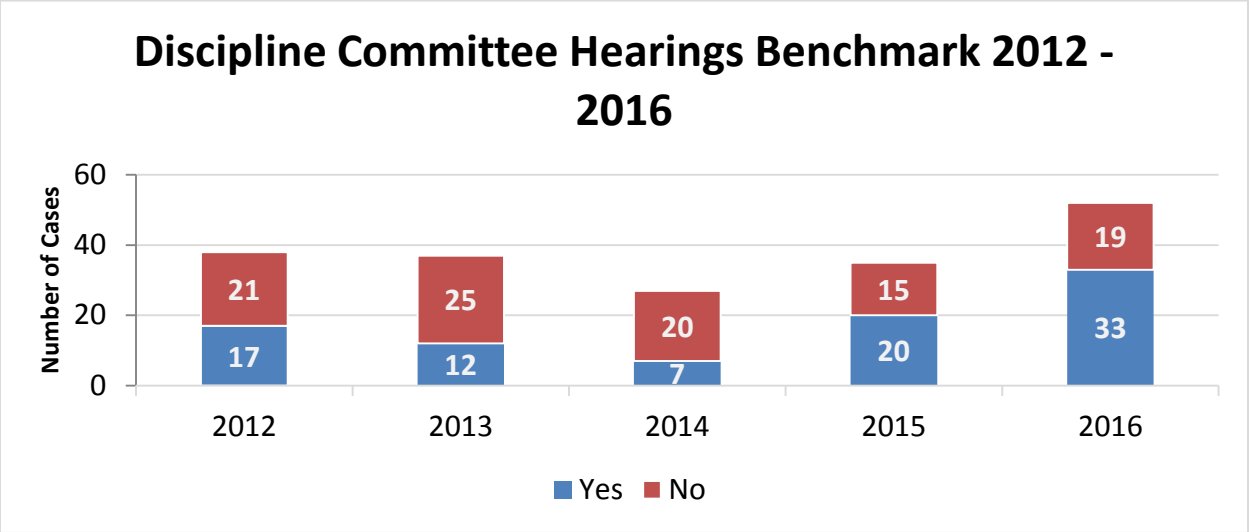


Hearings and Decision Benchmarks

The Committee reviews its performance against the hearings and decision benchmarks.

Hearings Benchmark

The Discipline Committee has a hearings benchmark to commence and, if possible, complete hearings within 1 year of referral.



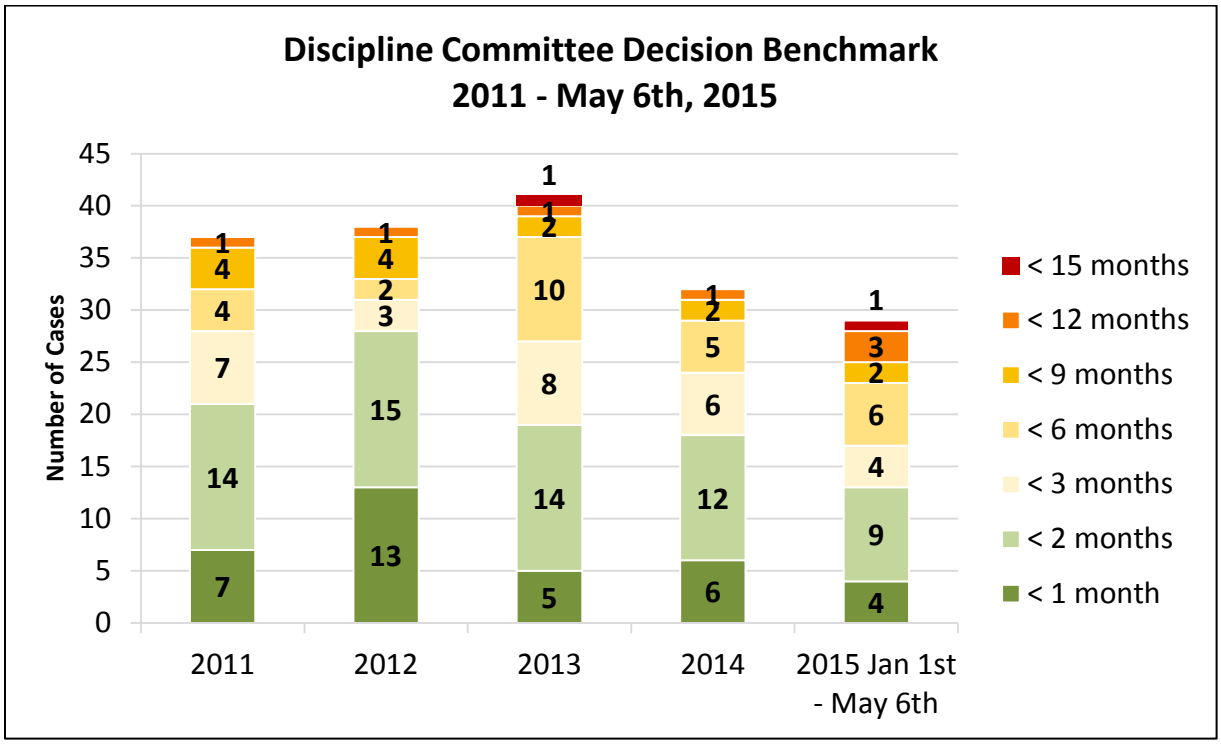
As of December 31st, 2016

Analysis of the reasons for variance indicates that cases are over benchmark based primarily on factors external to the Committee, including: the parties' readiness for a pre-hearing conference; concurrent proceedings which add to case complexity (concurrent discipline referral, fitness referral, criminal proceeding, judicial review or appeal); postponements due to further investigation and the referral of additional allegations; and ongoing case negotiations. Factors internal to the Committee include the availability of days in the hearing calendar and panel availability.

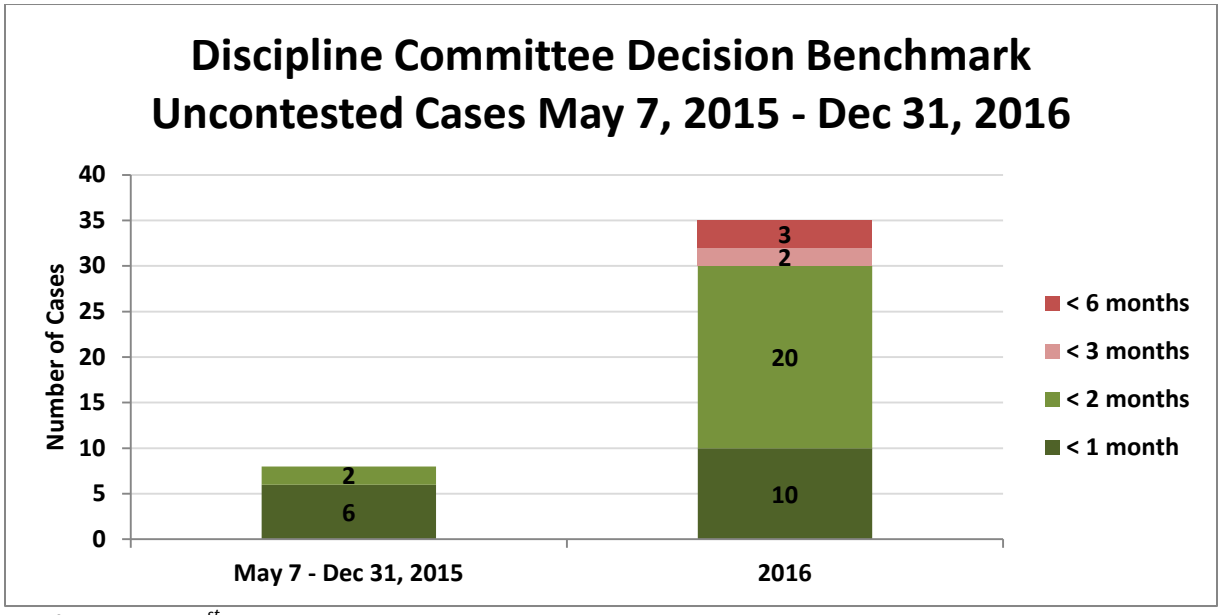
Decision Benchmark

In 2002, the Discipline Committee established a two-month decision-release benchmark for all cases. In May of 2015, the Committee changed this to two decision-release benchmarks to acknowledge differences in case complexity: two months for uncontested cases and six months for contested cases, absent extenuating circumstances.

Decision performance is reported below for the former benchmark and following for the uncontested and contested case benchmarks which came into effect May 7, 2015.

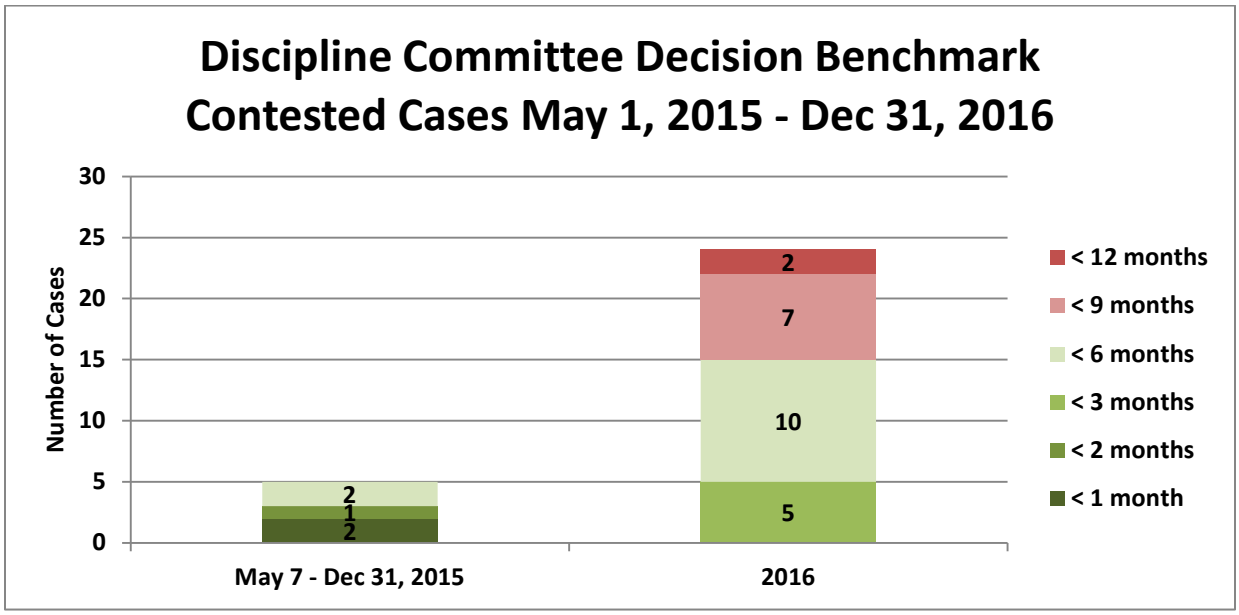


As of May 6, 2015



As of December 31st, 2016

**Please note that some cases included here may include matters referred in previous years.*



As of December 31st, 2016
**Please note that some cases included here may include matters referred in previous years.*

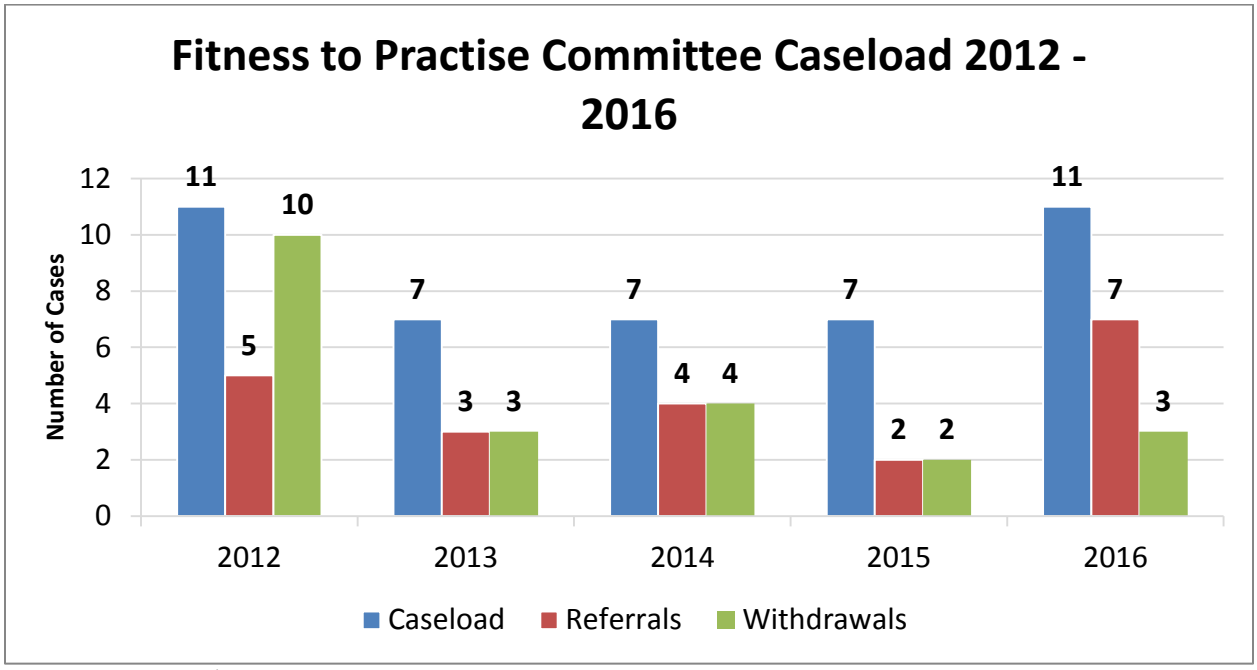
Appeals

In 2016, the Divisional Court dismissed two appeals by physicians and one physician abandoned his appeal.

Fitness to Practise Committee

The Fitness to Practise (FTP) Committee rarely hears cases, as matters of incapacity tend to resolve through health monitoring agreements with the Ontario Medical Association's Physician Health Program.

Caseload



As of December 31st, 2016

The dominant trend is to resolve incapacity matters through monitoring agreements, resulting in withdrawal of the allegation of incapacity before the Committee (three matters were withdrawn in 2016).

The FTP Committee had experienced increased pre-hearing and hearing activity from 2011 to 2013. However, FTP Committee referrals and caseload, which were on an upward trend, have decreased since 2012. Consequently, pre-hearing and hearing activity have decreased. Since 2011, there have been 2 to 6 PHCs per year.

There were seven referrals in 2016, a slight increase. There were no hearings in 2014, 2015 and 2016.

Compliance Monitoring and Supervision

The College's Compliance, Monitoring and Supervision Department (CMS) monitors all Committee decisions, undertakings and Orders arising from the several College committees, including the Quality Assurance, Registration, ICR, Discipline, Fitness to Practise, Premises Inspection and the Methadone Committees.

CMS continues to be challenged by the number of files that remain active compared to a lesser number of files that are closed within a year. The area monitors over 1300 active files.

CMS is finalizing a training program for Practice Monitors (i.e. chaperones) and physician supervisors which will be launched in 2017.

Throughout 2016, CMS has been refining the measures for assessing effectiveness and efficiency of its procedures and will continue in 2017 to work with the Statistician and IT to establish data needs and system requirements for broad and targeted data collection.

CMS has worked closely with other members of the Investigations and Resolutions Division, Medical Advisors, and Legal Division to plan for and respond to a cohort of Narcotics Monitoring System investigations by the College. This work is continuing into 2017.

Committee and Staff Education and Training

The ICR , Discipline and Fitness to Practise committees provide annual training in orientation, decision-writing, and chairing and utilize biannual business meetings to provide education on relevant topics, policies and practices of the Committee and the College and decisions of other committees, tribunals and the courts.

The ICR Committee incorporated educational sessions into the Committee's semi-annual business meetings. Dr. Sharon Cohen, Behavioural Neurologist and Medical Director, Toronto Memory Program, presented to the ICR Committee on Dementia.

Professor Rosemary Cairns Way, professor of criminal law, constitutional law and legal theory with the Faculty of Law at the University of Ottawa and senior educator at the National Judicial Institute, presented regarding the National Judicial Institute's Social Context Education Program to the Discipline Committee at its May Business meeting. Professor Cairns Way facilitated discussion about judicial continuing education regarding social context. Professor Cairns Way will continue to work with the Discipline Committee on its training curriculum including embedding social context education.

Mr. Charles Harnick, a trained mediator and former Attorney General of Ontario, presented on principled negotiation techniques at the Pre-Hearing Conference Chair and Panel Chair Training session.

Presenters at staff Division meetings included:

- Dr. Gary Bloch, family physician at St. Michael's Hospital, re: "Treating Poverty";
- Dr. Teodor Grantcharov, surgeon at St. Michael's Hospital, re: "Operating Room Black Box";
- Drs. Paul Dungey (Regional Supervising Coroner, East Region), Ruth Dubin (Co-Chair Project ECHO Ontario), Scott Duggan (Dept. of Anesthesiology and Perioperative Medicine), and Dr. Greg Murphy (Medical Director, Kingston Orthopaedic Pain Institute) re: Opioids; and
- Janina Fogels and Grace Vacarelli, Senior Counsel and Managers of Legal Services at the Human Rights Legal Support Centre, re: the Human Rights Code.

The Division introduced a revised standard investigator orientation/training curriculum for investigators and Compliance Case Managers which includes: fundamentals of effective fact finding; specialized investigation training; and cross team training.

Staff

I want to thank staff and managers for their outstanding work throughout the year.

Sandy McCulloch

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2016 DIVISIONAL REPORT

Legal Office

2015 ANNUAL REPORT TO THE COUNCIL FROM THE COLLEGE LEGAL OFFICE

Mandate and Objectives

The Legal Office's mandate is to conduct substantially all of the College's litigation[1] and to provide the bulk of the legal advice to the Council, committees and departments.

Core Activities & Statistics

Information about the civil proceedings, discipline prosecutions and appeals is presented, as usual, in separate documents. Other statistical information on discipline hearings is presented in the hearings office report.

Ongoing Activities

Staffing

The Legal Office has a current complement of fourteen full-time counsel and nine administrative staff. One of the lawyers is a corporate lawyer, the others litigators. The office continues to run under the co-director model adopted in January, 2009, with Vicki White and Lisa Brownstone sharing the director duties.

Legislation/ Regulations

In 2016 the Office spent a fair bit of time on legislative and quasi-legislative initiatives, including work related to the Goudge report and what is now Bill 87. The Legal Office continues to support requests made of government for various legislative and regulatory change (IVF facilities, legislative change requests outside of those being actively considered by government, etc.)

Litigation

The number of discipline referrals continued to increase in 2016. As of December 2016, there were 89 outstanding discipline referrals at various stages of proceeding, as compared to 71 in December 2015, and 56 in December 2014 (Note there are currently about 100 cases on the list). One case alone in 2016 lasted for well over 30 hearing days.

The College also successfully defended a number of appeals in 2016. Of significance was the successful defence of a constitutional appeal in the case of Dr. S Sliwin. Although the reasons were released in 2017, the appeal was argued in June, 2016. In addition, in 2016, the College brought a successful appeal to the Divisional Court of a Discipline Committee penalty. (Note that the member in this case – Dr. Peirovy- has been granted leave to appeal this decision to the Court of Appeal). In addition, a significant amount of resources were spent in 2016 on the applications challenging the

[1] We are not involved in the College's employment law issues. As well, outside counsel is retained by the insurer when we are sued civilly for claims for which we have insurance coverage.

constitutionality of the College's Human Rights and MAiD Policies (to be argued in June 2017).

There were the usual judicial review proceedings, registration hearings at HPARB, and other, more standard appeals.

The legal office continues to be involved in cases involving the suspected performing of controlled acts by non-members. We expect to have more to report on this activity during the course of 2017.

Much work has also been done by the office in working on various aspects of the opioid issue, both at a general and a member-specific level.

Other Matters of Significance

As always, the Legal Office continues to be involved in many of the College's ongoing initiatives, such as providing legal support for the ongoing work on the Quality Management Partnership with Cancer Care Ontario. The Legal Office also continues to support regular College activities, programmes and policies, such as the Premises Inspection Committee, registration initiatives, the QA Committee, the annual renewal process, and governance processes and related by-laws.

Respectfully submitted

Lisa Brownstone
Vicki White

19 April 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Policy and Communications
2016 Annual Report

Policy and Communications 2016 Annual Report

Overview

The Policy and Communications Division provides strategic and operational support in a number of areas including policy development, internal and external communications, issue management, public and government relations and governance. The Division coordinates and supports the work of four College committees: Patient Relations, Outreach, Governance and Council Awards. Committee support and coordination also extends to policy-specific working groups.

Major Functions

Policy

- Development and review of policies to provide guidance to physicians about legislative/regulatory requirements and the expectations of the medical profession
- Coordination and management of consultations
- Research and analysis of issues related to medical regulation
- Development of submissions to government, agencies and external stakeholders
- Support for corporate initiatives and projects

Communications

- Coordination of all media relations activity
- Strategic communications (internal and external)
- Website development and maintenance, management of social media presence
- Publications including Dialogue, Patient Compass, specialty newsletters (OHP/IHF, medical students), Annual Report
- Editorial and design support for a range of products
- Coordination of external outreach activities
- Public and physician inquiries
- Coordination of Council Award program
- Coordination of all public relations activities

Government Relations

- Management of relationships with government
- Strategic oversight and support for all activities with government
- Monitoring of legislative initiatives of interest to the College
- Coordination of all submissions to government

Governance*

- Coordination and support of the Governance Committee including:
  - Coordination and support for all nominations activity
  - Coordination and support for Council, committee and committee chair performance assessment/feedback process
  - Strategic support for College leadership
  - Development and review of governance policies (together with legal counsel)
  - Coordination and support of the district election process

* Note: Governance activity is reported as part of the annual report of the Governance Committee.

2016 Highlights

1. Policy

Policy review and development are core activities of the Policy Department.

The goal of policy review is to ensure that College policies fulfill the College's public interest mandate, and provide clear, current and useful guidance to the profession and public. Development of new policies is undertaken in accordance with the direction of the Executive Committee and Council to respond to emerging trends or issues.

In addition to policy review and development, Policy performs a number of other core functions including project support, legislative monitoring and issue support and management. Approximately 50% of the work of the department falls within this category. This includes the following:

External Consultation Requests or Initiatives: This includes reviewing, assessing and developing responses to external consultation requests that come to the College. These requests are from a broad range of stakeholders including government, medical regulatory authorities, Ontario health regulatory colleges and health-related organizations on matters relevant to the College and its mandate.

Submissions & Legislative Monitoring: Legislative monitoring includes regular review of the Legislative Assembly of Ontario, Ontario Gazette and other sources for emerging legislative developments that have relevance to the College and the health regulatory landscape. Where applicable, pertinent draft legislation is reviewed and analyzed and submissions are developed on matters relevant to the College, either in response to draft legislation, initiatives or other relevant issues.

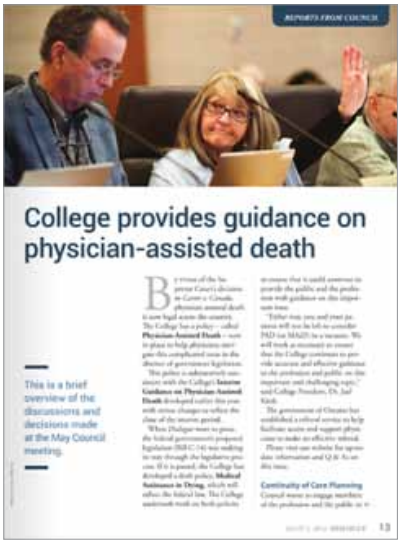
Support of College Projects and Initiatives: Policy provides ongoing support to a broad range of College projects and initiatives. This has included support in relation to the Sexual Abuse Initiative and the Minister's Sexual Abuse Task Force, the Peer Redesign project, Medical Assistance in Dying and Outreach events.

Committee Support: Support is provided to College Committees, including Registration, Education, Quality Assurance, Methadone, Premises Inspection and Investigations Complaints and Reports Committees.

Patient Relations Program: The department manages and supports the College's Patient Relations Program. This involves managing the ongoing activities related to the Patient Relations Program; and supporting the Patient Relations Committee.

Professionalism in Undergraduate Medical Education: The 'Professionalism and Practice Program: Undergraduate Medical Education' was launched in 2013, and Policy currently has central responsibility for its ongoing development and administration. It was developed to fulfill Council's objective to engage medical students on issues of self-regulation, professionalism and ethics.

2016 Policy Highlights



College provides guidance on physician-assisted death

This is a brief overview of the discussions and decisions made at the May Council meeting.

Over 2016, Policy was engaged extensively in the issue of medical assistance in dying. Three policy documents were developed and approved by Council over the first six months of 2016 to ensure the College could provide guidance and direction to physicians, in keeping with a shifting legal landscape: Interim Guidance on Physician-Assisted Death, the Physician-Assisted Death policy, and the Medical Assistance in Dying policy. In addition, Policy developed a number of companion documents for physicians and patients on medical assistance in dying including Frequently Asked Questions documents for physicians and for the public, a Fact Sheet explaining the 'effective referral' requirement. Policy coordinated a number of submissions to external parties including submissions to the Senate Committee, and to the Provincial/Territorial Expert Advisory Group. Two additional policies were approved in 2016: Physician Treatment of Self, Family Members, and Others Close to Them, and Physician Behaviour in the Professional Environment, and amendments were made to two existing policies: the Prescribing Drugs policy and the Planning for and Providing Quality End of Life care policy. Nine policies were under active review including Accepting New Patients, Ending the Physician-Patient Relationship, and Test Results Management.

New Policies/ Statements	**5**	• Interim Guidance on Physician-Assisted Death: January 2016 • Physician Treatment of Self, Family Members and Others Close to Them: February 2016 • Physician Behaviour and the Professional Environment: May 2016 • Physician-Assisted Death: June 2016 • Medical Assistance in Dying: June 2016
Policies under Review or Development	**9**	• Ending the Physician-Patient Relationship • Accepting New Patients • Block Fees and Uninsured Services • Change in Scope • Re-entering Practice • Test Results Management • Practice Management Considerations • Physicians and Health Emergencies • Continuity of Care
Active Policy Working Groups	**3**	• Medical Assistance in Dying • Accepting New Patients/ Ending the Physician-Patient Relationship • Continuity of Care/Test Results Management

Legislation/Regulation Development or Response	**3**	• Submission on Bill 119, Health Information Protection Act • Medical Assistance in Dying: Submissions to the Provincial/ Territorial Expert Advisory Group, House of Commons Committee, Senate Committee • Fertility Oversight : Regulation Amendment Proposal
Consultation Responses to External Stakeholders	**21**	Including: • HPRAC • Ministry of Health and Long-Term Care • Ministry of Transportation • Health Canada • College of Nurses of Ontario • College of Optometrists of Ontario • College of Massage Therapists • College of Opticians of Ontario • College of Physicians and Surgeons of Alberta
Support: Initiatives and Projects	**4**	The support provided has included the following: • Sexual Abuse Initiative/Task Force • Peer Redesign • Fertility Services and OHPIP • Opioids

Consultation Process Improvements

Policy consultations continue to be a key element of the policy development and review process, and we strive to ensure continuous improvement of this process.

The consultation process is inclusive, transparent and extensive. Invitations are sent electronically to all College members, and to a broad range of other stakeholders including patient and physician organizations. All consultation materials are posted publicly and are accessible to all interested parties. Respondents are provided with a number of ways in which they can offer feedback, and all feedback received is posted publicly.

Improvements continue to be made to the look and format of the web pages developed for each policy consultation. The transparent nature of the process allows all enabling participants to view the comments of others and to see how the College has responded to the feedback through policy revisions.

An overview of the policy consultations undertaken in 2016 together with the response rates are captured below.

Total number of responses received in 2016: 1058

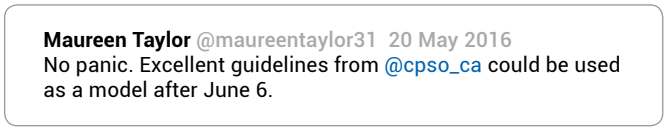
Average number of responses received per consultation: 105.8

Consultation-specific breakdown:

1. Physician-Assisted Death (carries over from 2015): **533**
2. Physician Behaviour in the Professional Environment (carries over from 2015): **46**
3. Physician Scope of Practice (prelim): **163**
4. Test Results Management (prelim): **97**
5. Re-Entering Practice (prelim): **29**
6. Practice Management Considerations… (prelim): **32**
7. Continuity of Care (prelim): **64**
8. Physicians and Health Emergencies (prelim): **57**
9. Ending the Physician-Patient Relationship (includes responses received prior to Jan 1, 2017): **19**
10. Accepting New Patients (includes responses received prior to Jan 1, 2017): **18**
11. Proposed Regulation Change: College Oversight of Fertility Services: **23**

Public opinion polling is used to inform the policy development and review process. Polling results provide Council with valuable perspective about the views and perspectives of the public. Public expectations and perceptions help inform sound decision-making in the public interest.

Social media tools (namely, Facebook and Twitter) have been used extensively to promote policy consultations too help us reach a different and broader audience. This practice, which began in late 2012, continues to be used to complement the consultation process.



Top 5 policies visited on the website for 2016	Unique Page Views: Jan 1 – Dec 31, 2016	Avg. Unique Page Views Per Month
Medical Records	54,250	4,521
Confidentiality of Personal Health Information	32,264	2,689
Prescribing Drugs	26,534	2,211
Mandatory and Permissive Reporting	23,664	1,972
Consent to Medical Treatment	21,675	1,806

2. Communications

The Communications department strives to develop timely and effective internal and external communications. The department also coordinates and supports the public affairs and media relations functions. The communications team develops and supports a broad spectrum of communications products in support of College decisions and programs. We work to ensure that stakeholders, members and the public are informed about and engaged in College work.

2016 Special Focus -- CPSO 150TH ANNIVERSARY

A number of activities were organized in 2016 to recognize the College's 150th Anniversary, beginning with our participation in the annual Toronto Doors Open festival. Over 700 members of the public visited the College on the weekend of May 28 and 29, to view an exhibit that included the history of the College, medical artifacts and general information about the College. Other anniversary activities included a dedicated 150th anniversary webpage, and several articles about our history in Dialogue and all our internal and external e-newsletters (e.g. Patient Compass, Assessor News, IHF/OHP News, Medical Student Update and the staff newsletter). Both the President's Dinner and the annual staff long-term service event featured anniversary themes.

COLLEGE WEBSITE

CPSO.on.ca is the primary communication vehicle for all aspects of the College's work. From our expanding public register to our dynamic consultation feature, it is how the majority of the profession and the public access information about the College. Improvements are always being made to content and navigation to ensure that information is up-to-date and relevant. In addition, the focus this year was to improve key components based on the College's strategic priorities and to determine what changes need to be made to support those priorities. Highlights include:

2016 WEBSITE STATISTICS

+2.6 million visitors
(2.2 million in 2015)

+9.3 million visits
(8.7 million in 2015)

+51.6 million page views
(49.9 million in 2015)

Most Visited pages:
1. The Public Register/Doc Search
2. The Homepage
3. Members' login
4. Members Info Tab
5. Medical Records policy

- **The creation of two complaints-related videos for the website.** The first, launched in May, focused on sexual abuse and featured Pamela Greenberg, our intake coordinator on sexual abuse complaints. The second, completed in late 2016 and launched shortly after the New Year, was another "whiteboard animation" video featuring Deputy Registrar Dan Faulkner, and talked about our complaints process more generally. To date, those videos have received more than 2,000 views.

- **The addition of a Continuing Professional Development (CPD) section for doctors.** There was a need to add vital information about CPD requirements for Ontario doctors to the website. Working with the

Research & Evaluation team, a section was built to point web users to various online resources, including CPD credits for College activities. To date, this section of the website has received nearly 15,000 page views.

- **150th anniversary celebration.** The "A Look Back" page on the website was updated to provide a comprehensive and interactive timeline of CPSO activities and milestones going back to our founding in 1866. This page update coincided with our participation in the Doors Open Toronto event in May 2016, where the College set up a museum-style exhibit in its hearing room that featured much of its rich history. The page has received over 2,200 page views since it was updated.

- **The development of the new CPSO Policy app.** In 2016, we worked with a George Brown student group to develop a mobile app that would allow users to more easily access CPSO policies on mobile devices. This app, which is nearing completion, also features the ability to provide feedback on CPSO policies and download copies of CPSO Dialogue.

DIALOGUE AND ANNUAL REPORT

The College's magazine Dialogue is our most important communications product. It is published shortly after each of the year's four Council meetings. It conveys the work of the College and includes College expectations for the profession. In addition, every issue of Dialogue includes summaries of the College's discipline decisions to ensure the profession is aware of the outcome, the rationale and the expectations of the profession. Dialogue is sent to the entire profession and many key decision-makers and stakeholders including MPPs, health care leaders, and other groups and organizations.

In addition to regular columns and features, we highlighted, over the previous year, such issues as Physician Assisted Dying and Continuity of Care. With each article, we emphasize the importance of feedback from the profession to our policy consultation process and direct readers to the website to share their thoughts and opinions.

In 2016, the magazine published a number of articles on matters related to opioids. We did interviews with experts on the importance of function scores, explained the dangers of abrupt cessation, alerted the profession to the availability of naloxone and discussed the new changes for the prescribing and dispensing process for fentanyl patches. We will continue to have significant coverage of this important issue well into 2018 as we intensify our efforts to promote safe prescribing.

Other notable issues included a cover article that paid tribute to our 150th anniversary. This milestone was tied into our annual appreciation issue and underscored the importance and evolution of physician involvement in medical regulation.

With our social media properties now well established, we also use Dialogue to consistently drive the conversation online as often as possible, whether it pertains to the development of a policy or an important undertaking, such as the College's Sexual Abuse Initiative. Conversely, with a growing number of Dialogue articles themselves being the focus of tweets, social media allows us access to readers who

may not have otherwise read a particular article or are even familiar with the publication.

To augment our 2015 annual report, we again used a compelling infographic to highlight a busy and productive year. Our online infographic allowed readers to click onto any one of several "read more" icons in order to be taken to a particular section of the annual report for more details. This was the first year that we did not publish a small print run of the annual report.

NEWSLETTERS AND COUNCIL AWARD

E-NEWSLETTERS

In addition to Dialogue magazine, the Communications Department produces several e-newsletters targeted to specific stakeholders:

Medical Student Update is produced three times a year and each issue contains information developed specially for the medical student audience. In 2016, articles featured included professionalism, mistreatment of trainees, sexual abuse and physician assisted death. Students are also encouraged to participate in our consultations.

Patient Compass: Patient Compass is directed to our health care consumers and advocates. The four issues published in 2016 covered a range of current health care and regulatory issues of interest to the public, such as MAID, the sexual abuse task force and Bill 87, opioid prescribing, and invitations to participate in our various policy consultations. We also included articles with practical advice on general health related topics such as best practices when using the internet to research personal health concerns.

IHF/OHP News is produced twice a year for physicians working in independent health facilities and out-of-hospital premises. In 2016, articles provided practical advice on maintaining regulatory obligations, information on significant changes to facility standards and updates on relevant policy consultations effecting IHF/OHP facilities.

Assessor News: Assessor News is produced four times a year for the physicians, nurses and other health care professionals who conduct physician and facility inspections/assessments on behalf of the College. Peer Redesign was a significant focus in 2016, with several articles reviewing this initiative to make program assessment tools and procedures more relevant to specific disciplines of medicine.

Council Update: Council Update is produced four times a year immediately following each Council meeting to share the decisions and areas of focus and discussion from the meeting. It is also our first opportunity to encourage participation/feedback on consultations on a variety of issues.

COUNCIL AWARD

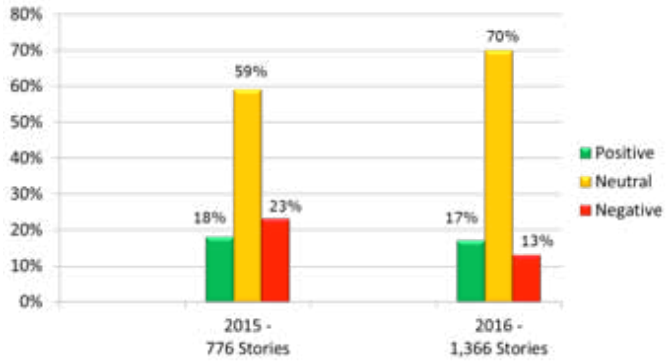
Four awards were presented in 2016 to Drs. Stephen Feder, Amanda Bell, Martin White and Mohit Bhandari. Efforts to modernize our nomination process by making better use of electronic/internet promotional opportunities resulted in a marked increase in the number of nominations received for the 2017 award cycle.

MEDIA RELATIONS

The work of the College is closely followed and scrutinized by the media. Each year, the College receives hundreds of inquiries about physicians who are under investigation or before the Discipline Committee, and about our policies and initiatives. Responses to daily requests for information are developed on a wide variety of topics. We also actively reach out to media on a range of issues, and respond quickly to requests for information or interviews.

Much of the media focus over the past year has been on action the College is taking respecting its priority initiatives. This includes our work to ensure safe opioid prescribing, our efforts to prevent and improve the way that we deal with sexual abuse of patients and, more recently, our response to Bill 87. One area of continued and sustained focus pertains to support of the 'effective referral' requirement that is set out in our human rights and medical assistance in dying policies. We always look for opportunities to generate accurate and balanced coverage of our high profile initiatives and of the decisions made by our College Committees.

Looking at the volume of coverage in 2016, without doubt it was the busiest year to date. There was sustained interest from media on discipline cases, investigations, and CPSO policies and programs, with almost four news items about the College on average per day. The College was also the subject of focused attention from faith-based media on policies that set requirements for conscientious objectors.



Overall, the tone of the coverage was 17% (236 stories) positive; 70% (961 stories) neutral; and 13% (169 stories) negative. In comparing the 2015 and 2016 results, we saw a reduction in the percentage of negative stories from 23% to 13%, and an increase in the percentage of neutral stories from 59% to 70%.

Two main factors have been identified that have led to the 76% increase in the amount of media coverage about College activities. In 2016, Canada saw a major national policy change with the introduction of medical assistance in dying. Our interim guidance and subsequently our Medical Assistance in Dying policy was mentioned in 320 articles, often with the CPSO perceived as a leader in providing good guidance to the profession, and in collaborating with government to ensure a smooth introduction of this service.

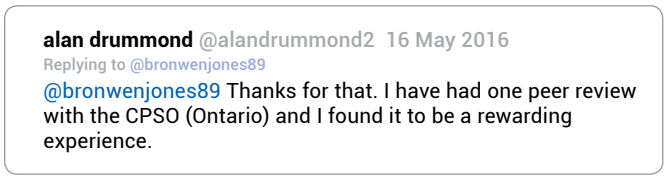
The buyout in 2015 by Postmedia of the Sunmedia chain has also resulted in a major increase in the

number of mentions about the College in certain circumstances. Before the buyout, a higher profile article in the National Post might have appeared in a handful of Postmedia affiliated papers. Now the same article in the National Post might also appear in a number of Sunmedia's 25 community papers in Ontario.

We began in 2016 to look at the volume of our coverage in terms of whether the article is 'unique' or a 'viral' story and we continue to monitor this in 2017. While the above-mentioned are two factors which have led to the significant increase in volume, unmistakably the media is interested in College activities and we anticipate this will continue.

SOCIAL MEDIA/WEBSITE

Our social media tools are used to provide help in real time to doctors, members of the public, and organizations who are looking for information or assistance.



We also use social media to promote a wide variety of College publications, announcements, career opportunities, media releases, and more. In addition, we live tweet each Council meeting and we have seen some real interest from a broad audience of media and health care stakeholders who have shared the outcome of significant discussions and decisions at Council. In 2016, we relaunched our popular "Policy Trivia Tuesdays" contest, in which we tweeted out every Tuesday a question regarding CPSO policy, and our followers tweet back the correct answer for their chance to win a prize. We also provided comprehensive social media support for a number of key College initiatives, including Medical Assistance in Dying (MAID), the CPSO's position on opioid prescribing, and the preliminary groundwork on the development of a net new Continuity of Care policy.

OUTREACH PROGRAM

The College's Outreach Program reaches out to members and the public on key College issues, targets specific areas of the province with organized events and participates in a variety of medical student and resident events.

In 2016, the Outreach Program had a strong focus on improving the public's awareness of the CPSO's mandate and educating the members on our key issues and policies.

2016 Outreach by the Numbers	
23	Member outreach meetings with the profession: Academies of Medicine, medical staff associations, hospital rounds
10	Public outreach events including: Doors Open Toronto, Estate Planners Council of Hamilton, CARP, The National Association of Federal Retirees, The PROBUS club
9	Resident Education Session: Relationships with Industry, Professionalism, Medical Assistance in Dying, Consent, Transitions to Practice
15	Medical student engagements including: Convocation addresses, orientation week sessions, topics of professionalism, Ontario Medical Student Weekend
27	Medical leadership, health regulators, and other intra-professional groups
84	**Total outreach meetings with key CPSO target audiences**

HIGHLIGHTS

- **Medical Assistance in Dying (MAID)**
  - o Several key CPSO spokespeople were equipped and dispatched to speak on the topic of MAID
  - o CPSO spokespeople completed 21 presentations across the province

- **Increased opportunities for intra-professional collaboration**
  - o CPSO hosted the Federation of Health Regulatory Colleges Communications Conference
  - o Spokespeople also delivered seminars on Sexual Abuse to the College of Optometrists and a session on the Discipline Process with the Professional Engineers Ontario

- **Produced 3 issues of Medical Student Update: e-newsletter**
  - o Each issue contained critical information about self-regulation, professionalism and ethics geared towards medical students.

- **Sponsored Ontario Medical Student Weekend (OMSW)**
  - o 600+ Ontario medical students in attendance at OMSW hosted by Western University, London, Ontario.
  - o Students had an opportunity to ask questions at an interactive CPSO booth

- **Development and launch of the professionalism and practice webpage**
  - o The CPSO website now hosts downloadable modules on several professionalism topics for students and faculty to access. www.cpso.on.ca/professionalism

- **Continued regular engagement at medical school milestones**
  - o Registrar, President, Academic Council Representatives and Medical Advisors gave welcome and congratulatory remarks at medical class orientation sessions and convocation ceremonies across the province.

3. Government Relations

The role of the College, as well as our authority and powers, are set out in provincial legislation including the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code, and the Medicine Act. The government has entrusted the regulatory function of regulating the medical profession in the public interest to the College. Given the scope and nature of College work we are regularly called upon by government decision-makers to inform policy and program development and potential legislative changes. We work to contribute to the public discourse in areas that touch on medical regulation and matters of patient safety. We also respond to legislation that has implications for medical regulation and patient protection, develop and maintain productive relationship with government decision-makers and MPPs from all three parties, and are active participants in the legislative process.

The following outlines some of the main initiatives underway in 2016.

Legislative work

2016 was a busy year with respect to government relations activities. A number of pieces of legislation were introduced, both provincially and federally, of relevance to College work. We continued to work closely with the provincial government on a number of ongoing files of shared interest. Bill 119, Health information Protection Act, 2016 made major revisions to the Personal Health Information Protection Act, repealed and replaced the Quality of Care Information Protection Act and made amendments to the RHPA to require Colleges to collect personal information from members that is necessary for the purposes of developing or maintaining the electronic health record (EHR), and ensuring that members are accurately identified for purposes of the EHR. The College made a submission to the Standing Committee on Justice Policy about Bill 119 in March and asked for clarity on a number of elements of the Bill including how information is collected, new reporting responsibilities and consistency of language regarding mandatory reporting of privacy breaches.

In May, the College made a submission to both the Senate and House of Commons' Standing Committees examining Bill C-14, an Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying). College President Joel Kirsh presented in Ottawa at the Senate hearings.

At the end of the last legislative session of 2016, two Bills were introduced that we 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, set out a number of amendments to the RHPA including broad new regulation-making authority that would allow the Minister to make regulations related to all aspects of the structure of the College`s statutory committees including composition, panel quorum, eligibility requirements and disqualification grounds. It also expands the list of acts of sexual abuse in the Code that will result in mandatory revocation, proposes a new definition for the term `patient` for the purposes of sexual abuse and prevents ordering gender-based restrictions in cases of sexual abuse. Bill 84, the Medical Assistance in Dying Statute Law Amendment Act 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 College has also continued to work closely with government on a number of files of shared interest including physician assisted dying, prevention of sexual abuse of patients, the government's management of the public appointment process, the regulation of fertility services, facility oversight, and issues surrounding opioids and medication management.

GR Outreach

The College reaches out to and builds relationships with elected officials from all three political parties and their staff. These interactions with elected officials aim to build awareness of the College role in medical regulation and protecting the public, keep decision-makers informed about our policy and program work, and allow us the opportunity to influence legislation, regulation and policy directions of government.

PUBLIC AND PHYSICIAN ADVISORY SERVICES

The Public and Physician Advisory Service serves as the initial contact for members of the public and the profession. Advisors provide information about CPSO policies and assist with a wide variety of questions about physician practice. Advisory staff are the initial contact for complaints and resolve issues when possible and appropriate. They also assist physicians with all aspects of the annual renewal process. They respond to thousands of inquiries annually, via phone, e-mail, and written correspondence.

General Overview

In 2016, a total of 55,803 calls were placed to our frontline areas- Public Advisory and Physician Advisory Service (PPAS), reflecting a 3% decrease from 2015. The decrease in call volume is partially attributed to the increased success of the annual renewal process. Physicians are now more familiar with the online process and require less assistance. 92% percent of incoming calls were answered live in 2016 reflecting a 2% increase from 2015, and represents the department's highest achievement to date in this area.

Live call rates and abandoned call rates are part of the College's strategic dashboard under operational excellence. Our live answer target in 2016 was 85% and our call abandonment target was 10%. These targets were achieved or surpassed in all four quarters of 2016. The Advisors continue to serve as the primary contact for all annual renewal related inquiries, including Post Graduate inquiries. PPAS continues to manage all clinical related complaint calls and subsequent follow up, which account for approximately 33% of all complaint calls.

2016 Annual Call Volumes (All Queues)

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned 2016
2016	**53,803**	**49,330 (92%)**	**1,705 (3%)**	**2,768 (5%)**
2015	55,647	50,230 (90%)	1,751(3%)	3,666 (7%)
2014	60,850	51,247 (84%)	3,019 (5%)	6,584 (11%)
2013	66,671	46,841 (70%)	9,003 (14%)	10,823 (16%)
2012	63,851	53,503 (84%)	3,991 (6%)	6,357 (10%)

Public Advisory Service

- We continue to merge the telephone queues so that there is one contact number for both the public and physicians. As a result, more physicians are calling the number that was previously designated solely for members of the public. The total incoming call volume for 2016 decreased by 3% from 2015, which reflects both the lower call volume from members during the annual renewal process, and the increased live call response rate which reduces the amount of people abandoning the call and calling back at a later time.

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned 2016
2016	**50,131**	**45,937 (92%)**	**1,572 (3%)**	**2,622 (5%)**
2015	51,815	46,724 (90%)	1,593 (3%)	3,498 (7%)
2014	56,419	47,537 (84%)	2,363 (5%)	6,246 (11%)
2013	59,615	41,958 (70%)	7,844 (13%)	9,811 (16%)
2012	57,648	48,640 (84%)	3,291 (6%)	5,717 (10%)

Physician Advisory Service

- The total incoming call volume for 2016 decreased by 4% compared to 2015. The decrease in volume is attributed the fact that the public advisory extension continues to be published as the primary contact for both public and physician inquiries, and we expect this trend to continue. The 92% live call response rate is the highest achieved by the department to date.

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned 2016
2016	**3,672**	**3,393 (92%)**	**133 (4%)**	**146 (4%)**
2015	3,832	3,506 (91%)	158 (4%)	168 (4%)
2014	4,431	3,710 (84%)	383 (9%)	338 (8%)
2013	7,056	4,883 (69%)	1,159 (16%)	1,012 (14%)
2012	6,203	4,863 (78%)	700 (11%)	640 (10%)

Emails

- PPAS reviews and either replies to or forwards all emails sent to Feedback, the College's main address on its website for general inquiries.
- 5,685 e-mails were received in 2016, representing a 2% decrease over 2015.
- Advisory Services responded to 67% of these e-mails. Thirty-three percent were directed to other departments.
- 21% of the e-mails received related to the annual renewal process.

MAID

- PPAS served as the primary contact for all public and physician inquiries related to Medical Assistance in Dying.
- The department responded to 171 inquiries from both members of the public and the profession about MAID.
- Of the 171 public inquiries, 134 were copies of template letters/petitions addressed to the Ministry of Health and Long Term Care and cc'd to the College.
- The most frequent inquiry by physicians was for the Ministry's referral line.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2016 DIVISIONAL REPORT

Quality Management Division

The Quality Management Division (QMD) has three operational and one project unit:

- Applications and Credentials
- Membership, Corporations and Physician Register
- Practice Assessment and Enhancement
- Quality Management Partnership

Activities, achievements and outcomes for 2016 within these four areas are summarized below.

APPLICATIONS AND CREDENTIALS

(Processes activities for individuals who want to become members)

MAJOR FUNCTIONS:

- Assess applications for a certificate of registration for all physicians in Ontario
- Issue, renew or terminate certificates of registration
- Provide guidance for applicants through the assessment, training and examination systems in Ontario and Canada
- Provide guidance for applicants for all CPSO registration policies and pathways
- Direct compliance and supervision for restricted certificates of registration, such as supervision and assessment
- Facilitate the Changing Scope of Practice and Re-entry into Practice for all registrants and members
- Facilitate and implement initiatives and policies that increase access to CPSO registration for qualified candidates
- Support Registration Committee to fulfill their decision making authority
- Fulfill the reporting mandate to the Office of the Fairness Commissioner

ACHIEVEMENTS:

- 2.0% increase in the total number of new issuance of certificates
- 95% of certificates in all classes were issued well within the new 2016 benchmark service standard of 3 to 4 weeks
- Amendments to restricted certificates continued to decrease, down 43% from 2014, due in part to the new implementation of the amendment fee
- A program assistant pool was created to better use administrative resources and not increase staffing to manage increasing applications
- HPARB appeals have decreased for 5 consecutive years
- Inquiries staff achieved an 86% live call answer rate, surpassing the new 2016 increased service target of 85%
- For the 13th consecutive year more certificates were issued to IMGs than to Ontario graduates
- The scope of a project to automate the Registration Application for First Time Independent Practice Applicants was completed

- Creation and Approval of a mechanism to allow for Practice Ready Assessments in Family Medicine was achieved to allow for a 2017 cohort of physicians access to a certificate of practice, driven by the Office of the Fairness Commissioner and Ministry of Health
- Work continues with stakeholder engagement at the Post Graduate offices, Ministry of Health, CaRM's symposium, Touchstone Institute, Office of the Fairness Commissioner

OUTCOMES AND DATA HIGHLIGHTS:

Registration Committee Decisions

Applications Considered	2014	2015	2016
Total applications approved	1,446	1,247	1,154
Total applications refused	6	12	19
Total applications deferred	12	16	36
Total applications withdrawn	6	5	5
Total Applications Considered	1,470	1,275	1,214

HPARB Activity

Status of Appeals to HPARB	2014	2015	2016
HPARB confirmed the Reg. Comm. Decision	2	0	0
HPARB returned the case to the Reg. Comm. for reconsideration	0	0	0
Appeals withdrawn	3	2	1
Appeals outstanding	3	4	7

Inquiries of Applicants Serviced	2014	2015	2016
Calls Received	34,846	30,127	32,772
Calls Answered	29,172	26,005	28,261
Service Standard	84%	86%	86%
Written Correspondence	4,946	6,261	7,229
Customized application packages	2,230	2,508	2,636
Letters of Eligibility	1,411	1,306	1,188

Certificates of Registration Issued	2014	2015	2016
Independent Practice	1,524	1,624	1,593
Postgraduate Ed.	2,755	2,794	2,949
Restricted	364	551	361
All Other	24	24	23
Total Applications Processed	4,667	4,993	4,926

MEMBERSHIP SERVICES, CORPORATIONS AND PHYSICIAN REGISTER

(Processes a variety of activities for existing members)

MAJOR FUNCTIONS:

- Maintain the College Register and carry out various member services
- Assess applications for the authorization of medicine professional corporations and issue, renew or terminate certificates of authorization
- Issue Certificates of Professional conduct
- Ensure the annual renewal of general membership by collecting annual fees and by facilitating completion of the mandatory annual renewal form
- Ensure the most effective and efficient administrative processes to successfully renew the registration of 33,083 physicians
- Ensure adequate follow-up by specific departments related to individual physician responses to the annual survey, including follow-up with physicians not enrolled in CPD
- Coordinate annual renewal of over 4,500 Ontario postgraduate trainee certificates

ACHIEVEMENTS:

- Certificates of Professional Conduct: Achieved issuance of 7,241 certificates. Over 90% issued within defined service level of 5 days or less
- PGE Annual Renewal: The 2016 renewal process for Postgraduate Education certificates was completed faster than in any previous year with only 24 out of 4,579 renewals not completed by the due date of July 1, 2016. By comparison, in 2015 there were 47 late renewals and in 2014 there were 62
- Annual renewal for General Membership: The process of renewing over 33,083 members was carried out on schedule with no major issues or obstacles
- Late Renewals: Conducted successful follow-up of the 1,776 members who missed the June 1 due date, resulting in only 42 suspensions for non-renewal
- Certificates of Authorization: Processed record high 18,848 renewals of certificates held by medicine corporations. Processed 1,484 new issuances
- Physician Register Activities: Continued to process significant volumes of activity related to member resignations, undertakings, Registrar's notices, discipline entries, name changes, address changes. See figures in table below
- Online Member Portal: Increasing usage by members of the self-serve options in the online member portal. There were 21,465 online address and email updates made by members in 2016, a 15% increase over 2015.
- The College's Transparency Initiative in 2016 resulted in continuing new entries of information in the public register, e.g. criminal charges, SCERPS, cautions-in-person, discipline findings in other jurisdictions

OUTCOMES AND DATA HIGHLIGHTS:
Certificates of Authorization

Medicine Professional Corporations	2014	2015	2016
New Issuances of Certificates of Authorization	1,546	1,643	1,484
Renewals Certificates of Authorization	16,536	17,529	18,848

Certificates of Professional Conduct

	2014	2015	2016
CPCs Issued	8,220	8443	7,241

Renewals and Extensions of Postgraduate Education Certificates

	2014	2015	2016
Postgraduate Renewals and Extensions	4,926	5,362	5,254

Physician Register

Total Membership	2014	2015	2016
All Registration Classes	39,423	40,243	41,146
Independent Practice Class	31,313	31,803	32,405

Total Physicians in Active Practice in Ontario (excluding trainees, retired, out-of-province, etc.)	2014	2015	2016
	28,087	28,805	29,500 (estimated)

Physician Register – Related Activities

Physician Register – Related Activities	2014	2015	2016
Address Changes Entered by Staff (new & edits)	28,914	25,707	24,674
Address Changes –Entered Online by Members	10,710	16,518	19,367
Email Address Changes – Entered by Staff	896	1,659	1,665
Email Changes – Entered Online by Members	2012	2147	2,098
Resignations from Membership	780	965	907
Legal Name Changes	68	60	57
Foreign Embassy Letters[1]	578	640	564
Registrar's Notices	153	236	430

[1] Foreign Embassy letters are a service for persons travelling abroad with medical forms requiring certification that the physician who prepared the form is registered with the College

PRACTICE ASSESSMENT AND ENHANCEMENT

(Coordinate all assessments in the Quality Management Division)

MAJOR FUNCTIONS:

- Conduct Peer Assessments generally comprised of an onsite records review and an interview with feedback to the physician
- Conduct Change of Scope and Re-entry Assessments of physicians changing their scope of practice, re-entering practice, and comprehensive peer and practice reassessments that also encompass observation and interviews with colleagues and co-workers
- Conduct Pathways Assessments which include multi source feedback
- Conduct Out-of-Hospital Assessments of new premises as they notify to become operational, as well as existing premises on a 5-year cycle
- Conduct Assessments of Physicians wishing to maintain an exemption from Heath Canada to prescribe methadone
- Conduct Methadone Delegation exemption assessments in collaboration with Ontario College of Pharmacists which allows for the administration of methadone from community clinics
- Conduct Independent Health Facilities (IHF) assessments as requested by the MOH Director of IHF. IHFs are assessed on a 5 year cycle
- Update Clinical Practice Parameter (CPP) documents used in IHF assessments on a 5 year cycle
- Conduct Registration Assessments on behalf of the Registration Committee to determine if a physician should obtain an independent practice certificate
- Conduct Assessments of CPSO members providing anesthesia procedures in dental clinics. These assessments are conducted in collaboration with the Royal College of Dental Surgeons of Ontario
- Coordinate Assessor Network, providing support through administration of the Assessor Governance Framework, ensuring a consistent approach to recruitment, orientation and training of Assessors for QMD
- Support Peer Redesign which is developing an evidence based approach to assessment of physicians within a validity framework which will map onto all scopes of practice for which physicians are assessed

ACHIEVEMENTS:

- Hosted the 2016 Assessor Meeting – one and a half day event, half day for IHF/OHP assessors (88 participants) and 1 full day for the main event for all CPSO assessors (453 participants) – the largest turnout ever.
- Implementation new peer assessment processes based a review of identified gaps in data reporting requirements and proposed solutions to streamline work
- Implementation of the Assessor Governance Framework and the Assessor Statement of Commitment
- Launched the TELUS Suite EMR Training Video for assessors

- Piloted a revised Assessor Feedback Form to foster improved communications between the Quality Assurance Committee and the assessors about the assessment reports received
- Initiated Phase II of assessor orientation and training
- Contributed to the development of records management modules for use by general staff
- Worked with a Quality Assurance Committee Working Group to conclude the review of Pathways Assessments and initiate review of Peer Redesign assessments piloted in spring 2016.
- Collaboration on the development of new Peer Assessment tools and procedures as part of Peer Redesign initiative
- Quality Assurance Working Group prepared for review of first assessment reports in 2nd quarter; broader QAC training underway in anticipation of all MSI panels reviewing Peer Redesign reports in 2017
- Currently 17 disciplines engaged in peer redesign (8 having completed tool development and external consultation of assessment tools)
- Completion of required data collection in support of a Physician Factors project
- Committee Education – in addition to CPSO annual education the PA&E Committees continued to participate in additional planning/education sessions
- Hosted the annual Methadone Prescribers Conference attended by over 350 participants
- Updated the Independent Health Facilities (IHF) Clinical Practice Parameters and Facility Standards for Sleep Medicine in collaboration with the IHF Sleep Medicine Task Force
- Implemented definitions for nerve block procedures in the Changing Scope of Practice framework document “Expectations of Physicians who have changed, or plan to change their scope of practice to include IPM”. The definitions were developed by a Working Group in order to ensure a common understanding of procedures by physicians (i.e. pain physicians, supervisors, and assessors/inspectors) for their use in College processes (changing scope assessments, out-of-hospital premises inspections, and investigative processes.)
- Convened a Fertility Services Expert Panel that developed a draft Companion document to the OHPIP Standards, which will be used towards implementing a quality and inspections framework for the delivery of fertility services across the province (in response to a request by the Ministry of Health)
- Updated the OHPIP Standards to increase the responsibilities and duties of the Medical Director role in Out-of Hospital Premises (OHPs).
- Initiated an Independent Health Facilities (IHF) Task Force in order to update the IHF Clinical Practice Parameters and Facility Standards for Diagnostic Imaging
- Initiated a Changing Scope of Practice Working Group to develop a framework that would guide physicians not certified in Emergency Medicine, but wish to practice EM in a Rural Setting

- Initiated process to update two Changing Scope of Practice framework documents 1) Surgical Cosmetic Procedures, and 2) Endo-Colonoscopy
- QMD Committee Support area was responsible for the coordination of the five QMD committee meetings, including member specific and policy meetings, resulting in over 170 committee meetings in 2016. Decision Writers completed just under 3,200 decision letters to communicate Committee decisions

OUTCOMES AND DATA HIGHLIGHTS:

Type of Physician Assessment	2014	2015	2016
QA Peer Assessments	1,145	1,048	1,295
Change in Scope of Practice Assessments	21	32	36
Re-entry to Practice Assessments (through QAC)	6	3	3
Peer & Practice Reassessment (Comprehensive)	3		9
Methadone Assessments	79	87	98
IHF Physicians Assessed	311	298	465
OHP Physicians Assessed	50	111	382
Assessments for Registration Decisions	150	193	107
Pathways Assessments	631	612	422
TOTAL	2,396	2,384	2,817

Peer Assessment Outcomes

	Satisfactory Assessment			**Re-Assessment**			**Interview**		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
Overall	81%	80%	83%	11%	14%	12%	7%	6%	5%
Random	88%	87%	93%	8%	7%	5%	4%	6%	2%
Age 70	79%	76%	82%	12%	15%	14%	8%	9%	4%
Age 70+	76%	75%	86%	13%	14%	8%	11%	11%	4%

Pathway Assessment Outcomes

	Satisfactory Assessment			**Re-Assessment**			**Interview**		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
Overall	89%	87%	92%	6%	9%	3%	5%	4%	2%

Note: Number of exempted Pathway assessments - 94

Methadone Assessment Outcomes

	Satisfactory Assessment			**Re-Assessment or Interview**		
	2014	2015	2016	2014	2015	2016
1st Year Assessment	74%	60%	72%	26%	40%	28%

3rd Year Assessment	75%	76%	75%	25%	24%	25%
5th Year Assessments	87%	75%	73%	13%	25%	27%
Re-assessments	80%	79%	64%	20%	21%	36%

Facility Based Assessment Outcomes

Type of Assessment	2014	2015	2016
IHF	140	199	171
OHP	50	67	117
TOTAL	190	266	288

*In the fiscal year 2013/2014 there was an increase in the sale and return of IHF licenses which resulted in a lower number of facilities available for assessment.

Independent Health Facilities Outcomes

	Satisfactory Assessment			**Licensing Action Required by MOHLTC**		
	2014	2015	2016	2014	2015	2016
All IHFs	94%	97 %	99%	6%	3%	1%

Out of Hospital Assessment Outcomes

	Pass			**Pass with Conditions**			**Fail**		
	2014	2015	2016	2014	2015	**2016**	2014	2015	2016
All OHPs	40%	34%	38%	38%	39%	40%	2%	3%	8%

Note**:** In addition to Pass/Pass with Conditions/or Fail – 24 % of 2015 total Assessments were categorized as: Deferred or Not Rated. A decline was noted in the amount of pass outcomes in 2015 as the majority of inspections conducted were due to following up on clinic concerns and/or changes requested by the Facility.

QUALITY MANAGEMENT PARTNERSHIP

(Formal partnership, created by the Ministry of Health, between Cancer Care Ontario and the CPSO to develop provincial quality management programs)

MAJOR FUNCTIONS:

- Develop, implement and operationalize quality management programs for colonoscopy, mammography and pathology services. These programs include:
    - Facility standards and guidelines
    - Quality reporting at the provincial, regional, facility and provider level
    - A supportive three-tiered clinical leadership structure to foster continuous quality improvement and accountability

    - Resources and opportunities to support quality improvement
- The development of facility standards and guidelines to improve the consistency of care provided across all facilities
- Identify needs and training opportunities for clinical leadership that will foster a culture of continuous quality improvement
- Monitor and evaluate Partnership programs
- Link to health system stakeholders to leverage opportunities for implementing and championing the Partnership and its quality management programs
- Determine legislative and/or regulatory supports and strategies to support the Partnership and its quality management programs

ACHIEVEMENTS:

Three tiered clinical leadership structure established**:**

- Identified all 3 Provincial Leads, and 40 regional leads for the 3 service areas. Some regional lead roles need to be filled in Pathology.
- Recruited 99% of mammography facility leads, 100% for all other facility leads and administrative contacts
- Built a contacts database to manage contacts at every facility
- Launched the Provincial Quality Committees for each health service area

Identifying Facility Lead Competencies:

- Working with the Wilson Centre, University of Toronto, initiated a needs assessment to determine the activities and competencies for mammography Facility Leads and whether they feel prepared to perform them
- Results will be used to inform a training program for Facility Leads.

Generated and released QMP (quality management program) reports at the facility, regional and provincial levels:

- Generated a total of 561 reports (colonoscopy 197, mammography 268, pathology 96)
- Recipients included Provincial, Regional, and Facility Leads, and administrative contacts in hospitals
- Hosted three webcasts, one for each service area, to orient recipients of reports prior to distribution
- Created a supplementary information package for dissemination with reports for each of colonoscopy, mammography, and pathology
- Held 10 technical briefings in follow-up to distribution of the reports

QMP Facility Standards Integration:

- Designed an approach to adapt the colonoscopy and pathology facility standards into operable and measureable language and to facilitate the adoption of standards into key system stakeholders' programs, e.g., Quality Based Procedures (QBP), Canadian Association of Gastroenterology (CAG)

- Held working group meetings to embed the role of the Facility Lead into the OHPIP standards, which will be included in the OHPIP Standards companion document “Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy/Colonoscopy Premises”
- Council approved the proposed standards in February 2017
- A targeted consultation of the proposed standards is planned for in the spring/summer of 2017.

Program Evaluation:

- Established a working group that is charged with program and process evaluation
- Undertook the evaluation of the 2016-17 QMP reports, results to be presented in spring 2017

Launched the Citizens’ Advisory Committee:

- Developed and implemented a committee recruitment process
- Undertook a specific process to recruit a patient advocate chairperson
- This committee provides guidance on patient engagement/experience to inform QMP work as well as helping establish public reporting for the partnership.

Health System Reference Group:

- Supported the Healthcare System Reference Group which consists of system stakeholder organizations including Health Quality Ontario (HQO), Ontario Medical Association (OMA), Ontario Hospital Association (OHA), College of Nurses of Ontario (CNO) and academic, quality management representatives

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2016 DIVISIONAL REPORT

Research and Evaluation Department

The Research & Evaluation Department (RED) promotes the use of evidence for decision making and continuous quality improvement at the strategic and operational levels of the College. We use data that has been collected by CPSO through our large data systems, information that we have collected directly through interviews, focus groups and surveys and systematic reviews of the published literature. Through our multi-disciplinary expertise we apply qualitative, quantitative, and mixed- methods approaches to generate evidence to support evidence informed decision making in our medical regulatory environment.

Major Functions

The Research and Evaluation Department (RED) provides services to all College departments to assist them in using evidence and data-driven decision-making to fulfill their mandates.

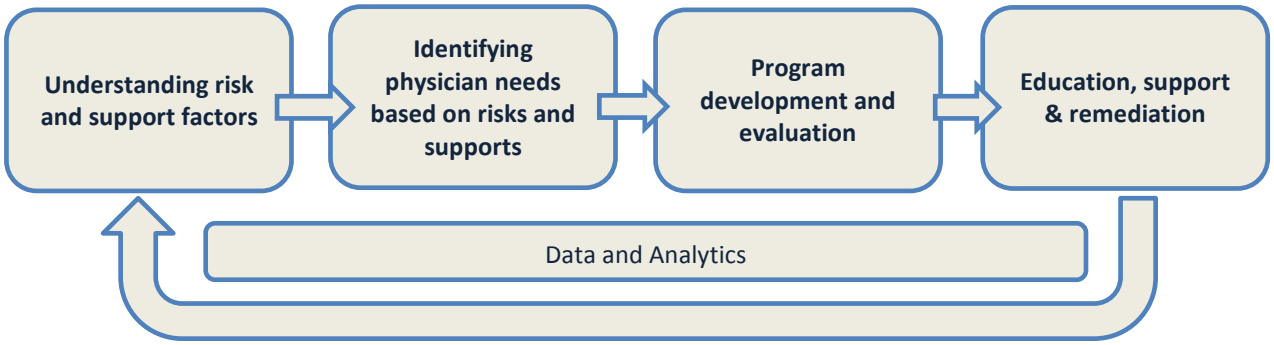
- Support physician assessment programs by developing and continuously improving rigorous, valid and useful assessment tools and processes
- Promote, facilitate and support program evaluation initiatives for continuous improvement in College programs
- Provide support to the foundational College activity of requiring all Ontario physicians to participate in continuing professional development (CPD) including tying relevant CPSO programs and initiatives to CPD opportunities
- Provide conceptual and evidence-based thinking to College activity pertaining to applying educational interventions to meet identified physician learning needs
- Facilitate a College-wide focus on outcomes measurement in physician improvement initiatives, including educational and quality improvement initiatives, remediation interventions and practice supervision
- Provide a range of services in survey methods, data collection and analysis
- Collaborate with external research partners to promote College research interests
- Develop and continuously improve mechanisms to collect physician factor information such as practice description/scope to ensure the College has relevant and current information about Ontario physicians and their practices
- Contribute to developing capability to continuously generate unique “College-knowledge” from College data; analyze and produce reports from College data to assist staff and program areas across the College
- Foster a culture of data-driven and evidence-informed decision making at the College

We are currently leading projects and strategic initiatives initiated by College departmental needs, and directed by Senior Management, Executive and Council. We

collaborate with relevant staff to ensure that projects are appropriately scoped and supported by all relevant stakeholders.

Overview

RED continues to guide the College toward a continuous physician practice quality and improvement system based on CPSO mandate. With continuous collaboration and consultation, RED developed the framework draft below to guide our work over the next few years:



RED uses data and analytics to support physicians' continuing competence through work in four key areas:

- Understanding risk and support factors of physician performance and practice outcomes
- Identifying physician needs based on those risks and supports
- Developing and evaluating assessment programs for physicians
- Developing and evaluating the education, support and remediation of physicians

Additionally, RED continues to provide general support for College programs through data analysis and program evaluations.

RED is leading two CPSO strategic initiatives:

- Education Strategic Initiative: To promote and support life-long learning for physician practice competence and public safety
- Data and Analytic Strategy: To develop quality data to inform decisions, support programs, improve practice and maintain member and public trust

RED also plays a key role in the advancement of applied research, evaluation and continuing medical education programming in the national medical regulatory context.

RED Achievements for 2016

A. Understanding the risk and support factors associated with physician performance and practice outcomes

1. Pan Canadian Physician Factors Steering Committee

Background and context:

- Colleges across Canada face a similar challenge to assure and enhance physician competence on a regular basis.
- A pan-Canadian regulatory Steering Committee was formed to provide oversight on:
    - Identifying, understanding and using empirically defined factors of practice that support physician performance or that suggest a risk of poor performance;
    - Developing and implementing alternative interactions between the College and physicians that serve to "provide feedback to physicians to validate appropriate care and show opportunities for practice improvement"; and
    - Alignment with, and greater physician participation in, local systems and supports that enhance their performance for safe and quality patient care.
- The project is led by the Colleges in Ontario and Alberta, with participation of BC, Manitoba, Quebec and Nova Scotia, FMRAC, external researchers, and several observing national bodies (e.g., CFPC, RCPSC).

Achievements for 2016:

- The Steering Committee has made significant progress in identifying an evidence-base for risk and support factors to guide College assessment programs.
- The CPSO is leading or contributing to all the projects under the umbrella of the Physician Factors initiative. Results from these studies will be shared with the factors steering committee and other national partners at the annual factors meeting in June.
- The national factors work was presented at IPAC and IAMRA in Melbourne, Australia.
- In addition to leading the applied research for CPSO, RED also plays a key role in supporting the Deputy Registrar as the Co-Chair of the national steering committee by helping to develop the infrastructure needed for the initiative.

2. Evaluation of the CPSO's Registration Pathways and Policies

Background and context:

- Over the past decade, the College has developed numerous alternative pathways to physician registration aimed at facilitating the entry of qualified and competent practitioners into Ontario without compromising quality of care or patient safety.
- The purpose of the evaluation is to understand the effectiveness of the CPSO's registration pathways and policies by comparing performance between physician registered through the traditional registration route and those registered through alternative routes.
- In order to investigate potential performance differences in practice, the following data sources were used to obtain a comprehensive picture of physician practice:
    - Peer assessment results based on patient record review and physician interview
    - Multi-Source Feedback results (Communication, collaboration, and manager roles)
    - CPSO complaints data
    - Quality indicators in family practice (through the Institute for Clinical Evaluative Sciences - ICES).
- This evaluation will enable an understanding of whether type of registration pathway is a "factor" or indicator of physician practice outcomes

Achievements for 2016:

- The collaboration with the Institute for Clinical Evaluative Sciences (ICES) was fully developed and preliminary analyses were completed. Data analysis for this portion of the study will be fully complete in 2017.
- All Pathway Assessments (Peer assessments with MSF) were completed, totally over 1700 assessments since 2013.
- The design for the Complaints analysis was finalized. Analyses will be completed in 2017.
- An analysis of performance differences across all data sources will be completed in 2017, and a report summarizing findings will be submitted to Council in December 2017.

3. Examination of full member data to understand factors associated with calls and complaints

Background and context:

- Under the “Understanding Risk and Support Factors” research stream of the National Physician Factors Initiative, this project aims to understand:
    - The nature and frequency of advisory calls for the Ontario physician membership in 2010 for the subsequent 5 years - 2011-2015
    - The demographic and practice factors associated with a) receiving an advisory call, and b) receiving a complaint in Ontario between 2011 – 2015 for the 2010 cohort of College members
    - Determine the utility of CPSO administrative data for analytics

Achievements for 2016:

- The analysis was completed in early 2017
- CPSO administrative data was successfully used to answer the research questions
- A report of the findings will be completed in late 2017

4. A qualitative study of the experiential knowledge of College assessors regarding physician risk and support factors

Background and context:

- College assessors have a wealth of experiential knowledge regarding the risk and support factors of physician performance.
- The purpose of the qualitative study is to interview assessors in Ontario, Alberta and Manitoba regarding these factors in order to supplement our knowledge of risk and support factors.
- It is acknowledged that there are likely factors that can be identified by assessors that have not yet been studied and therefore would not be accessible in the literature. Additionally, qualitative data will allow for a more fulsome understanding of what the factors mean, how they relate to each other, and how they are affected by different contexts.

Achievements for 2016:

- The study design was finalized and all interviews in Alberta and Manitoba were completed.
- All Ontario interviews will be completed in Q1 of 2017.
- A final report of findings will be completed in late 2017.

5. Project with ICES to understand the scope and magnitude of opioid prescribing in Ontario

Background and context:
As part of the College Opioid initiative, we applied to ICES to perform an analysis to look at physician's opioid prescribing patterns over time (including those not prescribing) and understand physician characteristics associated with different types of opioid prescribing behaviour. This will help CPSO understand the magnitude and intensity of opioid prescribing in Ontario to better plan appropriate and feasible programs.

- Interested in the spectrum of prescribing including extreme outliers (both high prescribers and those who are not prescribing at all)
- Interested in the physician demographic and practice factors associated with the spectrum of prescribing practice, controlled for specific patient cohorts (cancer, acute pain (emergency or post-surgical, others)
- Ensure alignment with other stakeholders, such as HQO and the MOHLTC

Achievements for 2016:

- The project was approved by ICES and initiated late in 2016
- Key principal investigator at ICES is one of the leaders in health services research relating to opioids (Tara Gomes)
- The findings will be complete in 2017

B. Identifying physician needs based on risks and supports

1. Testing a screening tool developed by the College de Medecins du Quebec (CMQ)

Background and context:

- The objective of this national project is to test the validity, reliability, and possible usage of the tool in various contexts:
  - By different age groups
  - Using multiple outcomes (peer assessments, complaints, multi-source feedback, etc.)
  - Across jurisdictions and regulatory environments
- In Ontario, the project will examine the tool across 4 age groups using peer assessment outcomes.

Achievements for 2016:

- Data was collected and entered throughout the year
- Analysis will be complete in May 2017
- Approach to using full member data and high level findings will be shared internally at the CPSO and at the Physicians Factors meeting in June 2017 as one piece in the collective national project

2. Physician Practice Taxonomy – ON HOLD

Background and context:

- This project originally started with aim to update 'practice codes' (i.e., descriptor statements about clinical practice) used on Annual Renewal and other College questionnaires (e.g., Physician Questionnaire)
- Practice activity data gathered on the Annual Renewal is used by numerous stakeholders both internally and externally (e.g., data that is shared with the Ontario Physician Human Resources Data Centre for provincial planning purposes)
- A Cross-College Scope of Practice working group was formed to both refine the CPSO practice codes and develop ways to better understand physicians' scope of practice

Achievements for 2016:

- This project is currently on hold

C. Program development and evaluation

1. Assessment Re-visioning: Peer Assessment Redesign

Background and context:

- Assessment Re-visioning is a multi-year, cross-College project to create a common assessment model and continuous quality improvement strategy for all College physician assessment.
- The Peer Assessment program was the first to be addressed, through the Peer Redesign project. The goals were to make the program discipline-specific, transparent, consistent, relevant, and aligned with its purpose of promoting physician quality improvement.

Achievements for 2016:

- Peer Assessment "Handbooks" (comprising the newly developed tools) were drafted for 10 disciplines and shared through external consultations with Ontario physicians.
- A phased implementation of the new assessment tools for these disciplines will begin in 2017.

- An evaluation of the new program will be conducted in tandem with implementation to monitor the efficiency of the new tools and processes and assess the outcomes associated with the program.
- New disciplines will begin to be initiated by the end of 2017.

2. Evaluation of Multi-Source Feedback (MSF)

Background and context:

- In 2012, Council directed an evaluation of Multi-Source Feedback assessment tools at the CPSO. The evaluation focused on:
    - The implementation of MSF at the CPSO and the processes associated with its operation
    - The outcomes and impact associated with MSF for key stakeholders
    - Critical factors needed to support potential integration and sustainability of the MSF program at the CPSO.
- Data was collected across key stakeholder groups over 3.5 years.

Achievements for 2016:

- Data collection for the MSF evaluation was completed.
- A report of findings will be completed in 2017.
- A summary of results will be presented to Council in May, 2017.

3. Evaluation of Legal pilot project: Provision of independent legal advice for complainants/witnesses in discipline hearings relating to sexual misconduct

Background and context:

- The Legal department is conducting a pilot project to provide independent legal advice to complainants/witnesses involved in discipline hearings related to sexual misconduct.
- RED is conducting an evaluation of this project in order to help assess its effectiveness in improving witnesses' experience of testifying.

Achievements for 2016:

- The evaluation plan was finalized.
- Data collection will occur in 2017.

D. Supporting Physician Education and CPD

The Education Team works across the College towards two broad goals:

- To liaise with internal (College) and external stakeholders to provide leadership and share information related to continuing professional development (CPD) and physician education
- To develop and integrate College activities, processes and systems in CPD and physician education, with a focus on supporting committee educational decision making, identifying and tracking physician learning needs, advocating for these needs to be met and measuring educational outcomes

1. Follow up on Recommendations from 2014 IEP Analysis

Background and context:

- In 2013-2014, a RED led cross-College working group conducted a retrospective analysis of Individualized Education Plans produced between 2010 and 2012 (IEP Analysis). The goals of this project were:
    - to obtain aggregate information on physician learning needs, interventions and outcomes (where possible) across College Committees; and
    - to make recommendations for improving and streamlining future IEP data collection, and educational processes across relevant College Committees
- The report included 29 recommendations, for which continued progress has been made against 11 in 2016

Achievements for 2016:

Progress against key recommendations included:

- In 2015, RED participated in a cross-College working group that developed a business case and job description for a new full time position in the Compliance and Monitoring Department dedicated to working with Supervisors and Practice Monitors. The position was filled in 2016.
- In partnership with Manager, Applications and Credentials, RED co-led a review of education decision-making by the Registration Committee, including the following activities/suggestions:
    - Piloted an approach for Committee referrals to the Registrar
    - Implemented a study plan template for applicants who have failed credentialing or certification exams
    - Piloted a way of tracking Committee decisions with education

2. Education Committee

- Education Lead continued to provide strategic leadership for the Education Committee including developing agendas and ensuring Education Committee has input into CPSO activity pertaining to CPD and physician education (including undergraduate and postgraduate medical education)

3. Sexual Abuse Initiative – Education and Training Plan

Background and context:

- As part of the College-wide Sexual Abuse Initiative (SAI) that began in December 2014, the Education Lead led a cross-College working group in scoping and beginning work on four broad, inter-related areas of activity related to education and training (see Figure 1 for key deliverables)

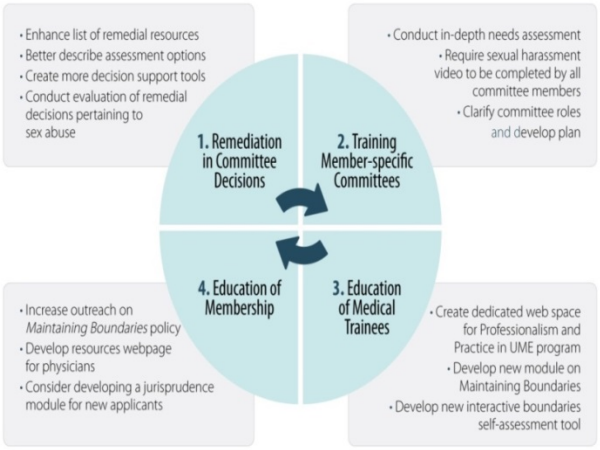


Figure 1: Key Deliverables in SAI Education and Training Project Plan

Achievements for 2016:

- Engaged an external consultant to conduct a scoping review on best practices for remediation of professionalism and communication issues and draft evaluation strategy. *Initiative included under Education Strategic Initiative.*
- Conducted an environmental scan and in-depth review of jurisprudence programs of Canadian medical regulators and Ontario-based health regulatory colleges.
    - Recommendation made and approved to establish a working group with responsibility for further scoping, and developing an implementation plan including timeline and budget for an orientation for new members.

  - Engaged an external consultant to scope a new orientation requirement including draft curriculum map.
  - Report on how to update 2004 Boundaries Self-Assessment Tool.
  - *Initiative included under Education Strategic Initiative.*
- Finalized module on *Maintaining Appropriate Boundaries*.
- Ongoing discussions by Policy Dept. with representatives from each Undergraduate Faculty of Medicine in Ontario related to content development and incorporating content from the *Maintaining Boundaries* module into their respective curricula.
- New *Professionalism and Practice* section on CPSO website.

4. Opioid Initiative – Education/Remediation and Supervision Plan

Background and context:

- As part of the College-wide Opioid Initiative that began in July 2016, the Education Team led a cross-College working group in scoping and beginning work related to the education/remediation and supervision of physicians identified through the Narcotics Monitoring System.

Achievements for 2016:

- Developed draft project plan.
- Maintain an up-to-date of list of opioid prescribing resources on the CPSO CPD/Practice Improvement website.
- Work with external educational partners to ensure the CPSO is aware of all relevant resources and remediation options in anticipation of a significant number of physicians who may require education or remediation.
- Developing a short-term strategy for ensuring that remediation and supervision plans (Individualized Education Plans) will be in place for all physicians requiring them as a result of investigations/assessments stemming from the NMS findings and to maximize consistency between IEPs.

5. Other

- Ongoing liaising with:
  - MS committees, committee support staff, Medical Advisors and senior management
  - three education consultants who provide individualized coaching and instruction in physicians referred for communication and professionalism issues
  - Ontario CPD offices

- Other external stakeholders (e.g., CPD-Ontario, CPD-COFM, CFPC, RCPSC, OCFP etc.)

E. Supporting College programs with data analysis

1. Routine member demographics and age shift

Background and context:

- Currently, the median age of the membership is above 50 years. This project will estimate the effects of the changing demographics on the membership and College resources into the next 10-20 years.
- Using CPSO routine data, this project will examine the changing demographics of the CPSO membership and its projected effects for the next 10-15 years

Achievements for 2016:

- Project plan and initial analytic codes were created. Draft population pyramids of the membership age/sex cohorts were created for each 5 year interval to 2030.

F. Education Strategic Initiative

Background and Context:

- Education was named as one of four Strategic Initiatives in September 2014 under the College's current strategic plan
- The Education Strategic Initiative was developed to integrate and coordinate physician education across all College Committees, programs and staff.
- Additionally, work on this initiative will ensure consistency with respect to physician needs assessment, educational activities/resources, data collection, outcome measurement and reporting

Achievements for 2016:

- In 2016 the Education Strategic Initiative was fully scoped out. The initiative will involve four main projects. Each of the projects, along with their 2016 accomplishments are described below.

- Developing a Long-Term Vision for Education at the College.

- A staff working group with representation from all areas of the College was formed with several tasks including reviewing current educational activity at the College; developing a Draft Role, Vision and Goal for education at the College; and creating a Long-term vision and strategy for education at the College.
  - The group met several times and completed an educational map of activities at the College, looking at proactive (preventative) education, reactive (remedial) education and educational data.
  - The group also commenced the development of a draft role, vision and goal for education at the College
  - Work will continue into 2017 with a goal of completing the long-term vision for education by the end of 2017

- Developing an Education and Evaluation Framework for Professionalism and Communications skills.
  - This project aims to develop two things: a consistent, evidence-informed approach to remediation of professionalism and communications issues across all four member-specific committees; and a strategy to evaluate the effectiveness of remedial efforts and the processes involved in remediating physicians with these problems
  - An external consultant was hired and performed a review of best practices in the remediation of communications and professionalism issues for physicians, with input from CPSO staff.
  - The external consultant was also completed, with CPSO staff assistance, an evaluation framework for these issues such that the College can monitor both the effectiveness of remedial efforts as well as internal processes involved in organizing remedial efforts for these physicians.
  - This work was overseen by a staff working group, who met regularly to receive progress reports and to contribute to the direction of the project.
  - The working group will commence the development of an implementation plan in 2017 with a view to piloting the remediation and evaluation approaches at the end of 2017

- Develop a New Member Orientation process for new applicants
  - This project will see the development of a mandatory educational program for new applicants to the College that will ensure that applicants will receive education on issues related to professional regulation, the College, and professional behaviour, including issues related to the prevention boundary violations and the sexual abuse of patients.

- In 2016 a working group worked with an external consultant who scoped out potential content for the educational module.
    - The content was finalized into a draft curricular content. The content was shared with several member-specific committees for content and revision
    - In 2017 the project planning will be finalized with a view to presenting to Council in September 2017 for final approval.
- Educational Data Mapping
    - This project is meant to look at how the College collects, stores and retrieves data related to educational activity at the College
    - In 2016 it was determined that this aspect of the Education Strategic Initiative is best positioned within the Data and Analytic Strategic initiative.
    - The Co-leads of the Education Strategic Initiative each participated in different working groups of the Data and Analytic Strategic Initiative.
    - In 2017 work will continue in this area.

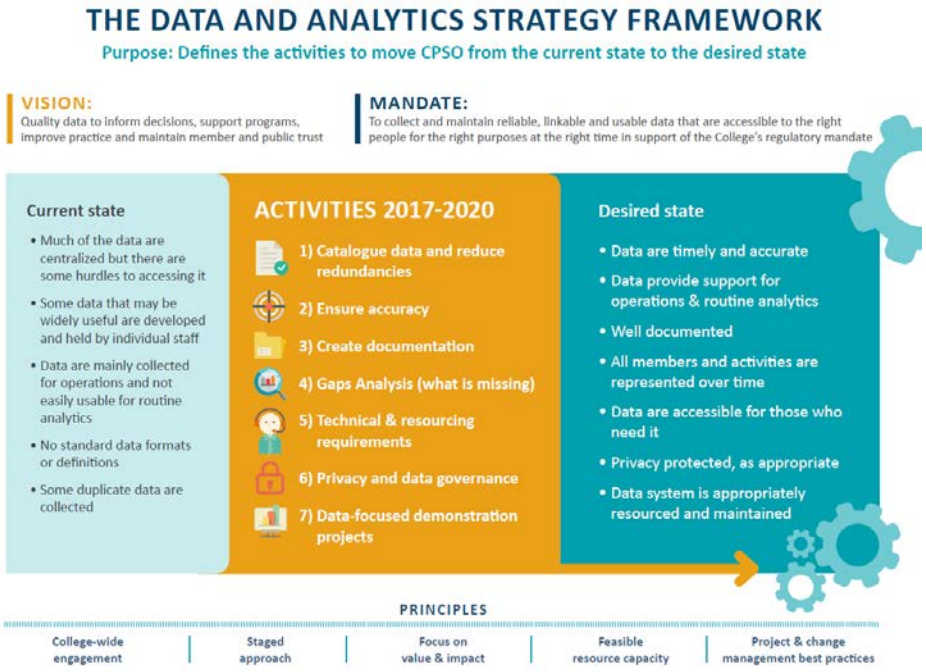
G. Data and Analytic Strategy

Background and Context:

- Data and Information Management was approved as a strategic initiative by Council as a component of the CPSO Strategic Framework for 2015 – 2018. In May 2016, work on the development of this strategic initiative began with the deliverable of a framework to move the initiative forward by end of 2016.

Achievements for 2016:

- Consultation and workshops with College staff occurred between May and September 2016 to determine scope, context and needs for data and analytics at the College.
- Framework development with staff in the fall of 2016
- A Data and Analytics Strategy Framework draft that outlines the vision and mandate of the strategy, the current state of data at the College, the desired state of data and activities and timelines to get started toward the evolution of the desired state was complete by end of 2016:



- An accompanying draft glossary of concepts and terms were developed
- A draft timeline plan was developed
- Plans to start a College wide data inventory project were drafted
- Plans to develop data focused demonstration projects, such as a review of the information collected in the annual review, were drafted to accompany the data inventory exercise

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: COUNCIL AWARD

DATE: MAY 25, 2017

FOR INFORMATION

ISSUE:

At the May 25th meeting of Council, **Dr. William Gary Smith** of Orillia, 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. Joel Kirsh will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402

Date: May 5, 2017

Appendices: N/A

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May/2017

TOPIC: PEER ASSESSMENT REDESIGN UPDATE– IMPLEMENTATION

FOR INFORMATION

ISSUE:

- Peer Assessment Redesign is focused on improving the quality of peer assessments by creating procedures and tools to structure and standardize assessments within distinct disciplines (Family Medicine, Anesthesiology, etc.).

- Twenty peer assessments using the new assessment tools have been launched to test the redesigned approach. Eleven disciplines are planned to implement new peer assessment tools in 2017 and all remaining disciplines not yet engaged in Peer Assessment Redesign are planned to initiate tool development over the next year.

- RED staff will provide a status update at the May 2017 Council Meeting on work supporting the implementation of the redesigned peer assessment program.

BACKGROUND:

- The strategic priority: "**Assure & enhance physician competence – assess every doctor every 10 years**" is addressed through numerous initiatives including increasing the effective impact of assessments through Peer Assessment Redesign (as part of the larger Assessment Re-visioning project approved by Council in 2011; see Appendix A)

- Peer Assessment Redesign has been underway since 2012 with a primary focus to develop new assessment processes and discipline-specific assessment tools by leveraging the expertise and experience of College peer assessors and input from internal College stakeholders.

- A project team in RED have worked with each assessor discipline group to increase the consistency and effectiveness of peer assessments by accomplishing 6 milestones:

    1. Drafting of new discipline-specific peer assessment tools
    2. Seeking internal feedback from all peer assessors within each respective discipline on the validity of the drafted assessment tools
    3. Training assessors in the use of new assessment tools and measuring the consistency by which assessors apply the tools
    4. Seeking external feedback from physicians and specialty organizations within each discipline on the appropriateness of new assessment tools

5. Finalizing assessment tools and integration of new procedures into the existing program
6. Continuous improvement of assessment through a sustainable periodic review plan

- The Peer Redesign team has regularly updated and sought input/direction from the Quality Assurance and Education Committees throughout the development of Peer Assessment Redesign. Council was last updated in December 2015.

- Two key assessment products are delivered through the Peer Redesign developmental process:

  - A discipline-specific Peer Assessment Handbook describes the key quality indicators for effective patient care and medical record keeping across eight assessment domains (e.g., History, Examination, Management Plans, etc.). These quality indicators are used to identify potential deficiencies and highlight opportunities for practice improvement. Accompanying evaluation criteria categorize the extent of improvement required to meet and exceed the standard of practice in each assessed domain.

  - Quality improvement resources (QIRs) were developed to provide a reference to topics of special relevance within a discipline and which may arise during peer assessment. These resources support consistency in assessor feedback and provide educational material to enrich the knowledge exchange between assessors and physicians. Topics vary by discipline and provide direction for quality improvement related to specific conditions, procedures, therapeutic modalities or examples of effective documentation formats.

CURRENT STATUS:

- To date, 17 assessor network groups have been engaged to redesign the peer assessment tools and procedures for their discipline (*development completed):

1. Family Medicine/GP*
2. Walk-In Clinic*
3. Hospitalist*
4. Medical Psychotherapy*
5. Dermatology*
6. Cardiology*
7. Endocrinology*
8. Psychiatry*
9. Emergency Medicine*
10. Rheumatology
11. Diagnostic Radiology
12. Anesthesiology
13. Haematology-Oncology
14. Long-Term Care
15. Geriatrics
16. General Surgery
17. Pathology

- Over the past 12 months, *external consultations* of draft peer assessment tools were initiated to solicit feedback from the profession and gauge whether practising physicians viewed the assessment tools as appropriate for evaluating care and driving quality improvement in their respective discipline.

- To date, 9 disciplines (including family medicine) have completed their external consultation with combined feedback from over 1,200 physicians and 14 physician organizations (e.g., OMA clinical sections, Ontario College of Family Physicians, etc.).

- External consultations have provided constructive feedback and shown consistent support of the new assessment approach across all disciplines. Assessor working groups used specific suggestions from individual physicians and physician organizations to refine the tools for their discipline prior to adoption in live assessments.

- *Internal feedback* on new assessment tools, procedures, and quality improvement resources was also sought from relevant College departments:

  - Staff supporting the operational side of the peer assessment program in the Practice Assessment and Enhancement Department (PA&E) worked with RED staff to integrate the new assessment approach into the existing operational framework.

  - The College's Policy Department provided initial feedback on the new peer assessment approach in 2016 to highlight key considerations for effective representation of College policies within the assessment tools. The Policy Department is providing ongoing policy reviews of each discipline's assessment tools to identify any required refinements or improvements to appropriately reflect College policy. This feedback will be integrated prior to the broad adoption of new assessment tools in each discipline.

  - The College's Legal Department has provided support to create appropriate framing language to clearly describe the intended purpose of new assessment resources (i.e., tools designed for education-focused assessment within a quality assurance context).

- A limited number of peer assessments have been launched to test the new assessment approach in Family Medicine and Walk-In Clinic practices in the first quarter of 2017.

  - Initial assessments using new tools in any discipline/specialty will be closely monitored to identify any refinement required to processes or further training to support assessors, the Quality Assurance Committee, and staff.

  - Implementation will proceed in a staggered approach with new disciplines/specialties adopting finalized assessment tools each year between 2017 – 2019.

- A two-step *program evaluation* of the redesigned peer assessment approach will accompany implementation:

  - Initially, a *process evaluation* will be conducted in tandem with implementation to ensure that the new assessment tools and procedures are being used as intended and that the new

assessment approach operates efficiently within the existing operational framework. Questions guiding this first phase of the evaluation include:

I. Are the redesigned assessment tools useful? E.g., Does the new assessment reporting approach effectively provide the Quality Assurance Committee with the key information required to inform decision making?
II. Are the new processes feasible? E.g., Is there a significant change in the length of time needed by the assessor to complete the assessment?

- An *outcome evaluation* will commence approximately six months following implementation of the program and will focus on evaluating the impact of peer assessment on assessed physicians' practice. Specifically, the assessment program must demonstrate that recommendations made during the assessment effectively provide direction for ameliorating practice deficiencies and highlight opportunities for quality improvement. In this second phase of the evaluation, key questions include:

I. What changes have physicians made to their practice as a result of the peer assessment?
II. To what extent did quality improvement resources support physicians' creation of practice improvement plans?
III. What aspects of the assessment process or factors within their own practice facilitate or hinder physicians' ability to implement practice change?

- Staff in RED and PA&E are also actively measuring and tracking the resource implications of the redesigned assessment program on operational staff, College assessors, and the Quality Assurance Committee. After initial implementation and acclimatization to the new assessment process, long term projections of program cost can be used to guide refinement and further development of the program.

NEXT STEPS:

- Staff in RED and PAE will continue to periodically update Council on progress made in the redesign of the peer assessment program and will highlight findings from the program evaluation and tracking of resource implications.

- As individual disciplines adopt finalized assessment approaches, new disciplines will enter into the developmental process. Staff in RED are currently targeting 2019 for the completion of assessment tool development in 33 distinct disciplines. A general assessment approach will be investigated for disciplines with very small physician populations (e.g., N < 50).

- RED will continue to work with PAE staff and College assessor networks to develop a feasible long-term maintenance framework for ensuring disciplines-specific assessment tools and

educational resources are periodically reviewed and revised, as necessary (e.g., reflecting College policy development, updating of clinical practice guidelines, etc).

This update is provided for information.

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Date: May 25th 2017

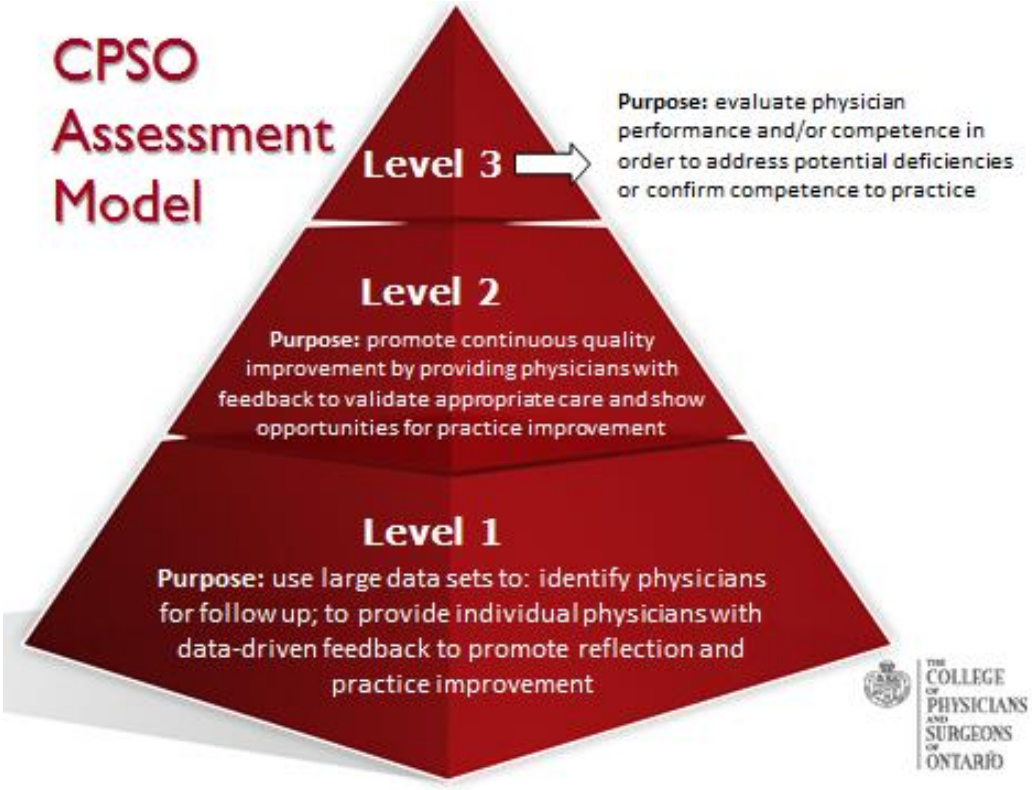
Appendices:

Appendix A - The Standard for High Quality Assessment

Appendix A

The Standard for High Quality Assessment:

In September 2011, Council adopted a vision for assessment at the College which included a unifying "College Assessment Model " with a definition of the purpose of 3 levels of assessments as well as a ***standard of quality*** in physician assessment. The assessment model grouped all physician assessment programs into 3 levels, each with a stated purpose (below). Peer assessment is considered a "Level 2" assessment.



The **Standard of Quality** was expressed as, "*High quality assessments use processes that are fair and transparent to yield outcomes which are reliable, accurate and effective (i.e. achieve intended purpose).*"

Maintaining the standard was expressed as, "*Evidence is collected continuously to contribute to assessment program validation which demonstrates that interpretations and actions (i.e. Committee decisions) stemming from assessment results are appropriate and effective.*"

Achieving High Quality in Assessment within Peer Assessment Redesign:

College staff in the Research and Evaluation Department (RED) operationalized the process of achieving and maintaining the high standard for College assessments by adopting the "Criteria for Good Assessment" (Norcini et al.[i]). A central RED mandate is to contribute to assessment program

development and ongoing monitoring through program evaluation so that the criteria for good assessment can be demonstrated. This approach and the accompanying evidence from evaluation of the program provide a well-structured and defensible argument for the validity of assessment programs.

The Criteria for Good Assessment:

1) **Validity or coherence:** There is a body of evidence that is coherent (‘‘hangs together’’) and that supports use of assessment results for a particular purpose.
2) **Reproducibility or consistency:** The results of the assessment would be the same if repeated under similar circumstances.
3) **Equivalence:** The same assessment yields equivalent scores or decisions when administered across different institutions or cycles of testing.
4) **Feasibility:** The assessment is practical, realistic, and sensible, given the circumstances and context.
5) **Educational effect:** The assessment motivates those who take it to prepare in a fashion that has educational benefit.
6) **Catalytic effect:** The assessment provides results and feedback in a fashion that creates, enhances, and supports education; it drives future learning forward.
7) **Acceptability:** Stakeholders find the assessment process and results to be credible.

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[i] These criteria were published as a consensus statement and set of recommendations from the Ottawa 2010 Conference, a leading conference on the assessment of competence in medicine and healthcare professions.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: CPSO Evaluation of Multi-Source Feedback (a component of the Pathways Evaluation)

DATE: May 25, 2017

Discussion

ISSUE:

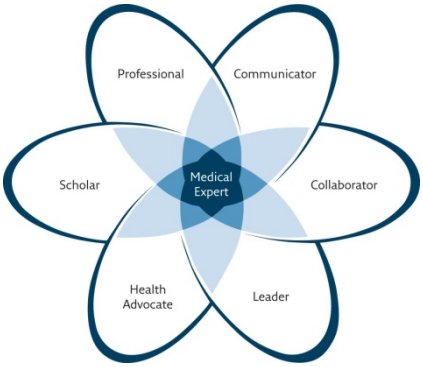
- The CPSO conducted a multi-year evaluation of physician practices based on their route to registration (i.e. a comparison of physicians that were registered by alternative pathways with those registered by traditional pathways – traditional pathways physicians are those who were fully trained in the Canadian context. This project, entitled "the pathways evaluation", included a comprehensive evaluation of Multi-Source Feedback (MSF) as used by the CPSO.
- Over the course of 2017, Council will be provided with information about the evaluation findings, analysis, and recommendations. This note will provide the key findings from the MSF evaluation, and describe several ongoing CPSO and national initiatives. These findings, the current environment for MSF nationally, and Council's response to the evaluation will all contribute to the development of recommendations related to the CPSO's future use of MSF.
- Council directed the pathways and MSF evaluation in 2012. The project team is seeking feedback from Council on evaluation findings.

BACKGROUND:

- A key strategic priority of the CPSO is to "Optimize the Registration Framework". In order to help achieve this, Council approved a project in 2012 to evaluate alternative licensure routes created primarily for internationally trained medical graduates to help fulfill physician shortages across the province **(Appendix A).** The goal of the project is to determine if performance differences exist for those registered via alternative licensure routes and those who were registered by traditional routes.
- As part of the evaluation, performance data was collected prospectively using an enhanced approach that augmented the current Peer Assessment Program (medical record review and assessor interview of physician) with a multisource feedback tool (MSF) licensed from the College of Physicians and Surgeons of Alberta. With approval from Council and under the authority of the Quality Assurance Committee (QAC), a specified number of Peer Assessments over 3.5 years had the MSF component added to it to assess physician roles in addition to the

Medical Expert role as exemplified by the CanMEDS framework (the primary roles assessed in MSF are Communicator, Collaborator, Professional - Figure 1). [1]

Figure 1: CanMEDS Physician Competency Framework



- This initiative is also aligned with the strategic priority to "Assure and Enhance Physician Competence":
  - The CPSO seeks to increase the number of assessments annually, which to date is principally in the form of on-site Peer Assessments and physicians assessed as part of an on-site facility assessment (e.g. Out-of-Hospital Premises Inspection).
  - The strategic priority also seeks to explore assessment options and the potential utility of MSF as a cost-effective screening, self-assessment, or evaluation tool.
- Since the MSF-enhanced Peer Assessments were launched in 2013, two related national collaborations aimed at enhancing physician competence have emerged, with extensive involvement of medical regulatory authorities:
  - The *Pan-Canadian Physician Factors Initiative (2015)* is currently studying the "factors" or characteristics associated with physician practice and performance (factors that may indicate a risk to practice performance and factors that may be protective). It is envisioned that medical regulators will use physician factors to assess physicians based on a common evidence base. Provincial programs to assure and improve physician competence are being developed and a common approach is to route physicians to an assessment with the appropriate level of "intensity" or "need" based on risk characteristics (this approach will necessitate different assessment options).
  - The Medical Council of Canada (in collaboration with medical regulatory authorities, physician organizations, academic partners and hospitals) acquired ownership of the CPSA MSF survey tools (in 2015) and is undertaking an expansive program development to improve and standardize the tools and the program of administering the tools, on a national basis (this initiative is now called *MCC 360*).

[1] The CPSO Council adopted the CanMEDS framework for assessment in May, 2015.

CURRENT STATUS:

- The MSF Evaluation focused on the following three key areas:
  - Implementation and the processes associated with its operation;
  - Outcomes and impact associated with MSF for key stakeholders;
  - Critical factors needed to support potential integration and sustainability of the MSF program.

- Data for the evaluation was collected from three key stakeholder groups: assessed physicians, the Quality Assurance Committee (QAC) and staff in the Practice Assessment & Enhancement (PA&E) department. Data was collected at the beginning, midpoint and at the end of the project through surveys, focus groups and interviews.
- A total of 1721 Peer Assessments that included MSF were initiated between 2013 and 2016. Each were assessments that would have been conducted within the Quality Assurance program to meet annual departmental targets. For each of these assessments, MSF was appended to the regular assessment process to collect data from two data sources.
- Of the 1721 assessments, 474 were administered to alternative registration pathways physicians while 1247 were administered to physicians obtaining licensure through traditional registration routes.

Key findings from the evaluation (discussed in the final report)

Costing information:

- The cost of a Peer Assessment with MSF is $1851.06 with Peer Assessment accounting for 81% of the cost (the average cost for MSF is $346.64).
- The incorporation of MSF also had time implications for the QAC and staff (time increased for both groups).

Feedback from the Quality Assurance Committee (QAC):

- Approximately 90% of the QAC agreed that there is value in assessing extended CanMEDS roles and that MSF adds value to the Peer Assessment process.
- QAC agreed with the use of the tool and were able to reach a combined score based on both data sources for all assessments. However, approximately half of the committee had difficulty making a decision based on two data sources for the following reasons:
  - MSF reports were sometimes hard to interpret without the inclusion of narrative comments.
  - Intervention and reassessment / follow-up options to address issues arising from MSF were limited.
  - Developing educational interventions for intrinsic CanMEDS roles (e.g., Communication, Collaboration, and Professionalism) is inherently more challenging than for the Medical Expert role.

Feedback from assessed physicians:

- 83% of assessed physicians agreed that an assessment including both Peer Assessment and MSF provided a comprehensive picture of their practice, prompted reflection and highlighted areas of success and areas for improvement in their practices.
- Assessed physicians were more motivated to make practice changes based on performance data from the Peer Assessment than MSF.
- Physicians who had the opportunity to speak to a Medical Advisor about their MSF results were more likely to make practice changes.
- Assessed physicians reported making the following practice changes as a result of MSF:
    - Stress management (e.g., attending to work-life balance)
    - Patient education (e.g., providing educational brochures for patients in the waiting room)
    - Communication (e.g., focusing on interactions with colleagues)
    - Practice Management (e.g., implementing regular staff meetings, improving patient flow)
    - Professional Development (e.g., attending local continuing medical education meetings)

Feedback from Practice Assessment & Enhancement (PA&E) staff:

- Staff felt adequately trained to administer Peer Assessments with MSF, but their satisfaction with processes declined throughout the project due to ongoing program development.
- Staff was extensively involved in the assessment administration; their feedback and suggestions (included in the report) provide valuable information for the development and implementation of future large scale projects embedded within routine operations.

Conclusions

- MSF is deemed acceptable among assessed physicians and QAC as a useful quality improvement tool to provide physicians with feedback.
- The utility of the performance data for physicians improves when a physician has a conversation with a Medical Advisor instead of receiving and attempting to use the report independently (this finding is supported by the assessment literature stressing the importance of facilitated feedback).
- Limitations were identified in the MSF tool/process that was used during this evaluation. For example, MSF currently only includes numeric ratings; narrative comments are needed to provide context for scores.
- The MCC 360 initiative is currently developing a comprehensive program that will address a number of current limitations identified in the CPSO evaluation, including the addition of narrative comments.

CONSIDERATIONS:

- None

NEXT STEPS:

- A comprehensive evaluation report is being developed and an Executive Summary has been provided at this time (Appendix B). The findings augment the existing scientific literature on MSF and identify some challenges in using MSF (that have also been identified by others), that will be addressed through the national MCC 360 program.
- Recommendations for the CPSO's use of MSF will be considered in a few months as national initiatives proceed.

DECISION FOR COUNCIL:

For discussion

Contact: Wendy Yen x263; Dan Faulkner x228; Wade Hillier x636

Date: May 25th, 2017

Appendices:

Appendix A: Council Briefing Note for Registration Program Evaluation (Feb 24th, 2012)

Appendix B: MSF Evaluation Report: Executive Summary

Appendix A

COUNCIL BRIEFING NOTE

TOPIC: Registration Program Evaluation

ISSUE:

- This project is a key part of the Council's strategic priority to "Optimize the Registration System."
- The purpose of the project is to design and implement a program evaluation to understand the effectiveness of registration pathways and policies.
- The evaluation will focus on learning what, if any, differences exist between practising physicians who achieved registration through alternative routes to registration and the traditional route to registration.
- The Registration Committee is overseeing the project in its entirety (e.g. coordination with other Committees, design, recommendations based on findings) and the Quality Assurance Committee (QAC) is overseeing a significant component of the project requiring the College's assessment expertise and infrastructure.
- Council is being provided with an update on the strategic project and a proposal to use the assessment infrastructure in the College. Council is also asked to provide direction on the project as it will inform two very important issues for the College's consideration in the future: (1) the testing and use of multisource feedback to obtain information on dimensions of performance not currently obtained, such as communication and collaboration; and (2) the consideration of indicators to direct focused selection for peer assessment (ie. Selection based on specified indicators).

BACKGROUND:

Program Evaluation

- The objectives of the program evaluation in registration are:
  - Contribute to the validation of alternative routes to ensure that pathways and policies are meeting their intended purpose;
  - Gain insight into the ways in which alternative route process changes may be useful, and
  - Better understand the educational needs of different physician subgroups to enable the development of appropriate quality improvement indicators.
- This project, directed by Council, will determine what, if any, differences exist in the practice/performance outcomes of physicians who achieve Ontario registration through alternative and traditional routes.
- Information learned from the evaluation will be valuable for several reasons:
  - The Registration Committee and Council will better understand the outcomes of their current policies and it will help to inform future policy

development;
- The Quality Assurance Committee will understand more about the specific quality improvement needs of certain physician groups;
- The results will contribute to the Quality Assurance Committee and Council's understanding of multisource feedback as one component of an assessment program in order to make future program decisions; and
- The results will contribute to the Quality Assurance Committee and Council's understanding of the pros and cons of focused selections for peer assessment (i.e. Selections that are not random but based on studied indicators that are associated with performance).

Registration Pathways, Policies and AIT

- In 2010, the Quality Assurance Committee considered how it could play a role in using quality assurance/improvement tools as one method to look at the quality of care and performance by physicians who enter Ontario through alternative registration routes.
- In June 2010 the QAC discussed the various registration routes, including physician mobility based on new legislative provisions in 2009. The QAC agreed in principle to consider selecting physicians for peer assessment using methods other than random and age-based criteria. This included consideration of all entry routes, such as the now-complete Registration Through Practice Assessment Program, pathways approved in 2008, other registration policies, and those entering through enhanced pan-Canadian physician mobility.
- The QAC agreed to receive more direction from the Registration Committee before proceeding on its agreement in principle.

A Plan for the Program Evaluation Using Existing Programs

- Throughout 2011, the Registration Committee and the QAC have been involved in the development of the program evaluation. It includes both a retrospective analysis of data that exists in the College and a prospective use of the assessment authority of the QAC to **assess** specifically identified physicians.
- The prospective component of the evaluation will look at somewhere between 500 to 1000 assessments over 2 to 3 years. The exact number will be determined using statistical and practical considerations, but will form part of the QAC's annual allocation of peer assessments (i.e. these will be "real" assessments in addition to the random and age-selected cohorts). The selection cohort will be based on the physician's route of registration and each physician selected will receive an 'enhanced' peer assessment, complemented with the use of tools to gain insight into their communicator and collaborator skills (multisource feedback). Both of these differences are described below.
- On December 15, 2011 the Registration Committee considered the need to conduct an evaluation of registration pathways to inform policy decisions. They requested the Quality Assurance Committee conduct assessments of physicians who have been registered by alternative and traditional pathways as part of the peer assessment selection process.
- The QAC considered the evaluation plan at its October and December 19, 2011 meetings. The evaluation protocol is attached as Appendix 1.
- The QAC is supportive of the program evaluation goals, the use of its assessment infrastructure, and the approach to enhancing the assessment with a multisource feedback model to obtain information that is not possible from the

existing peer assessment tools (CanMEDS roles such as communication and collaboration feedback are not assessed in a medical record review).

- The QAC is satisfied, after a comprehensive review of the risks, benefits, the literature and practical program considerations, that the evaluation protocol:
    - Will be fair to participants;
    - Will be transparent to all as a communication plan will be developed as part of the evaluation process;
    - Will enable the Committee to carry out its mandate and assessment goals with all selected physicians, and allow for the collection of useful data to make assessment decisions and facilitate practice improvements with members of the profession;
    - Will provide internal quality improvement for the Council as information will be used to (a) assist Council in making decisions about the use of multisource feedback within the overall quality improvement enterprise of the College and (b) assist Council in understanding the risks and benefits of selecting specific groups of physicians for focused peer assessments (in addition to the random and age-selected cohorts approach to date).
- Therefore the QAC is recommending the following:
    - That the QAC will select physicians for peer assessment in order to contribute to the program evaluation. Physicians will be selected to represent four alternative registration pathway cohorts (see Appendix 1), and physicians who have been registered by the traditional registration pathway will be selected based on matched characteristics (e.g., gender, age, medical specialty). Physicians in this latter group will be drawn from the larger pool of physicians who are randomly selected each year to undergo a peer assessment. The protocol will likely begin in late 2012 and extend into 2014. To be as transparent as possible, all selected physicians will be informed of the reason for their selection.
    - That the traditional peer assessment for the program evaluation will be augmented by multisource feedback in order to assess additional CanMEDS roles (e.g. Communicator, Collaborator). Note that the traditional peer assessment modules primarily assess the Medical Expert role and the record keeping competency of the Communicator role.
    - That there be a staged implementation of MSF, with the first stage being a pilot project on the 30 - 40 peer assessors who will be recruited as assessors to complete peer assessments based on the specialties seen through alternative registration routes. In stage one, the assessors will test the MSF tools on their own practice and this will form the basis of their subsequent training in the interpretation and use of MSF within a peer assessment. The second stage will involve the same assessors administering an "enhanced peer assessment" to physicians in the specified cohorts.

- On January 17, 2012 the Executive Committee supported the directions of the program evaluation.
- It is important to note that the evaluation protocol was developed to be part of current operations and is not a research study (i.e. the goal is to understand practice using existing applied tools of the College). The Committees agreed that the proposed design will optimize College resources, achieve multiple goals within the design and readily incorporate key lessons into our existing processes.
- The QAC is satisfied that it is using current concepts on how to assess physician

performance and how to effectively promote lifelong learning. Council heard from two Canadian experts in physician assessment and MSF at its November 2011 meeting. These experts presented on the sizable research into MSF and how its utility is enhanced when the feedback is integrated into a structured feedback process (see Appendix 2 for materials from these presentations).

DECISIONS FOR COUNCIL:

1. Council is asked to direct the staff, under the oversight of the Registration Committee and the Quality Assurance Committee, to implement the registration program evaluation by:
    a) selecting physicians who have obtained registration through alternative and traditional pathways to undergo a peer assessment beginning in late 2012 (approximately late Fall);
    b) augmenting the traditional peer assessment with assessment tools that will assess CanMEDS roles other than medical expert (eg. communicator and collaborator roles within multisource feedback (MSF) tools); and
    c) staging the implementation of multisource feedback tools by first conducting a pilot project with 30 - 40 peer assessors, followed by the implementation of an enhanced peer assessment for the physicians identified in (a).

DATE: February 24, 2012

CONTACT: Dr. John Jeffrey, Chair, Registration Committee
Dr. Eric Stanton & Dr. James Watters, Co-Chairs, QAC
Dan Faulkner, Rhoda Reardon, Wade Hillier (QMD)

Appendices

Appendix 1: Literature review and proposed evaluation design
Appendix 2: Presentations to Council on MSF

Appendix B: Executive Summary

Background & Context

Multi-Source feedback (MSF) is a 360-degree assessment tool that provides physicians with feedback from colleagues, coworkers, patients, and/or referring physicians. In 2012, MSF was incorporated into a subset of Quality Assurance assessments to evaluate the utility of the assessment tool at the CPSO. This evaluation aligned with two of the College's strategic priorities and two national collaborations the CPSO is involved in that are aimed at enhancing physician competence through assessments.

Alignment with Strategic Priorities

Optimize the Registration Framework

- Council approved a project in 2012 to evaluate alternative licensure routes.
- Performance data was collected for the project using the current Peer Assessment program in conjunction with MSF tools to assess CanMEDS[1] roles above and beyond the Medical Expert role.

Assuring and Enhancing Physician Competence

- The CPSO re-framed its strategic priority as the assessment of every physician on a ten-year cycle. In order to meet or exceed this goal, alternative assessments options need to be explored.
- MSF was introduced as a possible new assessment option that may be incorporated into CPSO assessments.

National Collaborations

The Pan-Canadian Physician Factors initiative

- The Pan-Canadian Physician Factors[2] initiative is currently studying the "factors" or characteristics associated with high and low quality physician performance. It is envisioned that physicians could be routed to an assessment with the appropriate level of "intensity" or "need" based on their characteristics. Other assessment options need to be explored if different "intensities" and "needs" are to be met.

Medical Council of Canada (MCC) collaboration

- The MCC (in collaboration with medical regulatory authorities, physician organizations, academic partners and hospitals) has acquired ownership of the MSF tool and will undertake an expansive research agenda to redevelop the tool and associated programming.

[1] http://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e
[2] http://www.cpso.on.ca/CPSO/media/documents/Council/Council-Materials_Dec2015.pdf#page=449

Project Stakeholders

Governance for the MSF evaluation was provided by CPSO Council and the Quality Assurance Committee (QAC). The Research & Evaluation Department led the development and evaluation of the MSF program. Other stakeholders include:

- The Practice Assessment & Enhancement (PA&E) department.
- Pivotal Research (third party vendor responsible for administering MSF).
- Physicians undergoing an assessment and their stakeholders (Colleagues, Co-workers, and Patients).

Program Overview & Tools

The MSF program was embedded in the existing CPSO Peer Assessment program for a 3.5 year timeframe. Each physician received a Peer Assessment with an MSF assessment. Both assessments were received by the CPSO and sent to the QAC for decision (No Further Action, Further Action) if necessary.

There are 7 different versions of the MSF tools, each suited for a different specialty type. Stakeholders respond to surveys items on a 5-point agreement scale. All mean scores are compared to a reference group; scores below the 10th percentile were "flagged" as being potentially concerning . Physicians could also be "flagged" to due low stress scores or missing stakeholder feedback.

Evaluation Purpose & Methodology

This evaluation will inform the possibility of using MSF tools within CPSO assessment programs. The MSF Evaluation focused on the following three key areas:

- Monitoring the implementation of the MSF program and the processes associated with its operation;
- Measuring the impact and outcomes associated with MSF on key stakeholders;
- Understanding the critical factors needed to support potential future integration and sustainability of the program.

Data collection was integrated into program operations. Throughout the 3.5 year project, multiple sources of data were collected across each of the key stakeholder groups, including assessed physicians, QAC members, and PA&E staff and managers.

Appendix B: Executive Summary

Findings: Process & Implementation

Program Implementation

- A total of 1721 MSF assessments were completed between 2013 and 2016. These assessments comprised up to 36% of all completed Peer Assessments in that time period.

MSF Processes & Tools

- The majority of physicians were satisfied with the MSF processes, however, recruitment of colleagues and patients was challenging for physicians in certain specialties and work environments.
- Physicians and QAC members were satisfied with the MSF tools, however, further tool development is needed to incorporate narrative comments from stakeholders and reduce the skewness of scores (currently most scores are in the upper range of the 5-point scale).
- Physicians indicated that MSF would be more valuable if it included a summary of areas for improvement and a link to appropriate resources or CPD opportunities.
- Physicians who did not meet a critical threshold on MSF had an interview with a Medical Advisor (MA). The MA interview was found to be an invaluable supplement to the MSF report as it provided physicians with facilitated feedback about their results and provided the QAC with contextual information for decision making.

CPSO Operations

- Staff and QAC felt adequately trained for administering the MSF program.
- The creation of a dedicated subset of the QAC for reviewing MSF reports was valuable for building consistency in how MSF reports were opined on.
- Staff satisfaction with processes declined over time due to iterative program development and concerns about workload and departmental targets. Staff also did not feel fully supported by technology to administer MSF assessments.

Findings: Outcomes & Impact

Assessment Outcomes

- Of the 1721 Peer Assessments with MSF completed, 584 (34%) were routed to QAC for review. Of these, 301 were routed because of concerns on the Peer Assessment, 228 because of concerns on the MSF, and 55 because both were potentially concerning.
- Of the MSF cases routed to QAC, 46% were due to low scores and 42% were routed because of missing stakeholder feedback.
- 87% who were flagged on MSF alone received decisions of No Further Action. Those flagged on both (Peer & MSF) had the highest proportion of interviews.

Impact on Physician Learning & Motivating Practice Change

- The majority of physicians felt that their assessment (Peer & MSF) prompted reflection, provided a comprehensive picture of their practice, highlighted areas of success, and highlighted opportunities for improvement.
- 64% of physicians agreed that the assessment helped them develop a self-directed quality improvement plan; 39% considered engaging in formal CPD/CME activities.
- 92% of physicians were motivated to make practice changes based on the Peer Assessment compared to 48% based on the MSF Assessment. The face-to-face interaction with the peer assessor was the most valuable aspects of the assessment for most physicians.

Impact on QAC Decision Making

- QAC agreed that it is important to assess CanMEDS roles beyond Medical Expert (i.e., communication, collaboration and professionalism).
- The majority of QAC agreed that MSF adds value to the Peer Assessment process.
- All of QAC agreed that the MA interview is a useful supplement to the report.
- While the MSF often provided QAC with useful information about a physician's practice, it only influenced their decision in 8% of cases. This reflects limited formal reassessment options for MSF-related issues. Future program development will focus on creating acceptable and valid follow up options for MSF.

Findings: Integration & Sustainability

Assessment Costs & Time Considerations

- The average cost of an MSF assessment alone is $346.64. The combined cost of a Peer Assessment with MSF is $1851.06, with the Peer Assessment accounting for 81% of the cost.
- The total cost for all 1721 MSF assessments over the course of the evaluation was $689,397.72 (without HST).
- QAC preparation time increased by 22% compared to regular Peer Assessments.
- MA interviews took, on average, 2hrs for Medical Advisors to complete.
- Coordinating MSF assessments and MA interviews with Pivotal and Assessed Physicians amounted to approximately 1.0 FTE.

Appendix B: Executive Summary

Conclusions

Strengths & Limitations of MSF

Strengths

- MSF emphasizes CanMEDS roles beyond Medical Expert and allows for feedback from a physician's patients and colleagues.
- MSF prompts reflection and is useful for validating appropriate care and providing positive reinforcement to physicians.
- The MA interview component of the program was valuable for providing physicians with facilitated feedback and for giving QAC contextual information to aid in interpreting MSF results.
- MSF is deemed acceptable among stakeholders.
- MSF and relatively less costly, compared to Peer Assessments.

Limitations

- MSF is currently not optimal for identifying specific areas for improvement for physicians or supporting QAC decision making
- Further tool development is needed to incorporate narrative comments and reduce the skewness of scores.
- Further program development is needed around remediation and follow-up options for MSF and for addressing the difficulty for some physicians to recruit stakeholders.
- It is important to note that facilitated feedback is needed when issues are identified through MSF.

Future Directions

The CPSO will strongly promote and actively participate in the national standardized MSF tool development and implementation (MCC360). MCC360 is a potentially strong addition to the system because it:

- addresses many of the concerns about the current tools identified in this evaluation (e.g. lack of narrative comments);
- will provide consistency and scientific rigour to a standardized tool across provinces and organizations;
- will facilitate medical regulatory authorities to trust and use MSF results across borders,
- will advance the use of MSF by physicians and reflection on CanMEDS roles that are not currently considered in CPD requirements, and
- enable wide scale research and evaluation to continuously improve the MSF model.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: Annual Fire Drill and Evacuation

FOR INFORMATION

ISSUE:

- **The College is required to hold a fire drill and building evacuation annually. This event will take place during the May meeting of Council.**

BACKGROUND:

- The College is required by law to ensure that all fire safety devices are tested and operational. This includes ringing of the fire alarms and a mandatory planned evacuation of the building.
- Staff and Council members are required to participate in the fire drill at the May meeting.

CONSIDERATIONS:

- Council members are frequently in the building for meetings and many have not participated in evacuation procedures. This opportunity will allow councilors to review the evacuation procedures and participate in a fire drill.

NEXT STEPS:

- Participate in the fire drill: evacuate the building and meet at checkpoint

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Contact: Krista Waaler, Ext. 384

Date: May 8, 2017

Appendix: Emergency Procedures for Council & Committee Members

EMERGENCY PROCEDURES
COUNCIL & COMMITTEE MEMBERS

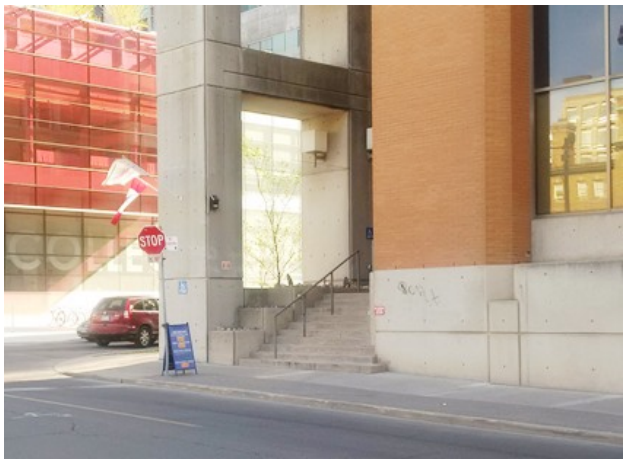
Upon hearing a fire alarm, the Committee Chair will stop the meeting.

With the back of your hand, test the door handle for heat and follow these steps:

- Door/handle is cool to touch
  - Brace yourself against the door and open slightly.
  - If you do not feel a resistance when you open the door, you are safe to leave the room.
  - Take the meeting role call with you to use as attendance
  - Exit with your group and close the door behind you.
  - Proceed to your nearest exit located near the washroom entrances. Do not use elevators.
  - Follow instructions provided by Fire Safety Team leaders and the Fire Department.
  - Once outside the building go to meeting check point (as seen below) and take attendance of your Committee members. If anyone is missing, report to the fire team (green hard hats).
  - Do not return to the building until it is declared safe to do so by the Fire Department or CPSO fire team.

- Door handle is hot or you have difficulty opening the door due to pressure:
  - Close the door and remain in the room.
  - Call the Fire Department at 9-911 and alert them of the address of the building (80 College Street) and your location (i.e. 3rd floor).
  - Call Security at extension 612 with the same information.
  - Seal off all openings, which may admit smoke.
  - Crouch low to the floor if smoke enters the room.
  - Wait for assistance from the fire department.

CHECK POINT – ONA Building



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

May 2017

TOPIC: Governance Committee Report:

For Decision:

1. 2018 Executive Committee Election

For Discussion:

2. Public Member President

For Information:

3. Appointments

- **New Public Members of Council**
- **Other Appointments**

4. Completion of 2018 Committee Interest Forms
(for submission at Council meeting)

For Decision:

1. 2018 Executive Committee Election

ISSUE:

- Council will elect the members of the 2018 Executive Committee, namely the President, Vice President, 1 Physician Council Member and 2 Public Members of Council.
- Nomination Statements have been received to-date from the following candidates for these positions: (attached in Appendix A).

For President: Dr. Steven Bodley

For Vice President: Dr. Peeter Poldre

For Physician Member: Dr. Brenda Copps
(1 position)

For Public Members: Ms. Lynne Cram
(2 positions) Mr. Pierre Giroux

- *Nomination Forms* with signature of nominee, mover and seconder are due at 12 noon on Thursday, May 25, 2017.
- Nominees will be given the opportunity to address Council, prior to the elections.

Decision:

1. Election of 2018 Executive Committee positions; President, Vice President, 1 physician member of Council and 2 public members of Council.

For Discussion:

2. Public Member President

ISSUE:

The Governance Committee is asking Council whether it wants staff to develop options that would facilitate the election of a public member president.

BACKGROUND:

- The CNO recently elected a public member president: http://www.cno.org/en/news/2017/march-2017/member-of-public-elected-president-of-body-overseeing-nurses/

- Other medical regulators across Canada have also elected public member presidents in the past (see Appendix B).

- Bill 87 has focused on the governance structure of regulatory college's councils and committees, and there have been suggestions that there should be a stronger role for public members.

- To that end, the Governance Committee had a preliminary discussion at the Governance Committee meeting held on March 24, 2017 about the potential for a public member president. Before developing options for how this might work, the Governance Committee wanted to ensure that the Executive Committee and Council supported this direction.

- At the April 25, 2017 Executive Committee meeting, the Executive Committee voiced support for having staff develop options that would facilitate the election of a public president of Council.

- This would be one of a number of steps the CPSO could take to modernize its governance structure.

CONSIDERATIONS:

- Currently, physicians elected to the Executive Committee progress to VP and President over the course of 3 years. This process is a CPSO practice, not a requirement in the existing by-law.

- There is value in being transparent about CPSO governance practices.

- The goal of any governance change should be to ensure alignment with the CPSO's public interest mandate. In this case, the goal would be that candidates for president are selected based on their suitability for the role, not whether they are public members or physicians.

- The role of the President will be reviewed to ensure that it can apply to both physicians and non-physicians.

- There are many ways to facilitate the election of a public member president:

    - One option could be general elections for each of the public member and physician member positions of Executive Committee and then election of a VP and President from the entire Executive Committee.
    - Assuming there is value in ensuring a CPSO President has experience on the Executive Committee; candidates for President could be required to have at least one year experience on the Executive Committee.

NEXT STEPS:

- If Council supports the direction for a potential public member for president, staff will prepare options for consideration by the Executive Committee. Options will be informed by a review of the governance practices of other organizations.
- Council will review the recommended option(s) for approval at the annual meeting of Council.

Question for Council:

1. Does Council support the direction for staff to develop options for facilitating the election of a public member for President?

For Information:

3. Appointments

New Public Members of Council:

- Two new public members have been appointed to the CPSO Council by the Lieutenant Governor of Ontario for a three-year term (see Appendix C):
    - Mr. Roy Marra, Caledon, Ontario: appointed March 8, 2017
    - Ms. Judy Mintz, Toronto, Ontario: appointed March 1, 2017

Other Appointments:

- At the Executive Committee meetings held on March 21 and April 25, 2017, the following appointments were made:
    - Ms. Judy Mintz: Inquiries, Complaints and Reports Committee
    - Mr. Roy Marra: Discipline and Premises Inspection Committees
    - Dr. Steven Bodley: Co-chair, Methadone Committee
    - Dr. Meredith MacKenzie: Co-chair, Methadone Committee
    - Dr. Janet van Vlymen: CPSO representative to Medical Council of Canada

4. Completion of 2018 Committee Interest Forms

- All Council members are asked to complete the Committee Interest Form for 2018 committees. (see Appendix D)
- Appended to the form are a description of each committee, a chart that identifies the average time commitment for each committee and Council work, and a committee chair role description.
- Public members are asked to identify a preference for the Discipline Committee or the Inquiries, Complaints and Reports Committee.
- The completed form will inform the Governance Committee in its deliberations as it develops committee recommendations for the 2018 Council year.
- Council members are asked to complete the Committee Interest Form and submit their completed forms to Debbie McLaren by the end of the Council meeting on Friday, May 26.
- Council will make committee appointments at the December meeting.

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

Date: May 5, 2017

Appendix A: Executive Committee Nomination Statements and Memo to Council
Appendix B: MRAs and Public Presidents
Appendix C: Orders in Council for Roy Marra and Judy Mintz
Appendix D: Committee Interest Form and attachments

Appendix A

NOMINATION STATEMENTS
FOR 2018 EXECUTIVE COMMITTEE VOTE

NOMINATION STATEMENT
CANDIDATE FOR PRESIDENT, 2018 EXECUTIVE COMMITTEE

DR. STEVEN BODLEY

District 8 Representative
North Bay, Ontario

Principal Area of Practice or Specialty/Occupation:
Anesthesia and Pain Management

Elected Council Terms:
2009-2012
2012-2015
2015-2018

CPSO Committees/Positions Held and Other CPSO Work:

Vice President:	2016-2017
Discipline Committee:	2010-2017
Executive Committee:	2015-2017
Finance Committee:	2016-2017
Fitness to Practise Committee:	2009-2017
Governance Committee:	2012-2014, 2016-2017
Methadone Committee:	2009-2011, 2014-2016 Chair: 2011-2014, Co-chair: 2017
Outreach Committee:	2016-2017
Premises Inspection Committee:	2010-2013, 2016-2017 Co-chair: 2013-2015, Chair: 2015-2016
Quality Assurance Committee:	2014-2017
Policy Working Group: *Delegation of Controlled Acts*	Chair: 2011-2012
Telemedicine Advisory Group (e-Health Statement, and Telemedicine	2012-2015
Interventional Pain Management Working Group on Change in Scope of Practice	2011-2012
"Guide to Applying the Out-of-Hospital Standards in Interventional Pain Premises" Working Group	2010-2011

STATEMENT:

It is with a mixture of excitement and trepidation that I put myself forward for election to the office of President for 2017-18.

It is a position I feel well prepared for having worked on several committees and working groups since being elected to Council in 2009. I have had the support of my fellow Council members and from College Staff every step of the way and will need your support in the coming year more than ever. Recent events have lead the Executive to bring forward a number of initiatives that have the potential to dramatically change the way we go about our business. Next year as well we will be losing the experience and steady hand of Rocco as he retires, and I will be working with our new Registrar as we chart our future.

It is reassuring that in the midst of these changes I will be working with your Executive team that consistently functions at a very high level. To be elected to head such a skilled group of leaders is indeed humbling, and I promise to approach the role of President with energy and strength, and with my eyes always firmly on maintaining public trust.

NOMINATION STATEMENT
CANDIDATE FOR VICE PRESIDENT, 2018 EXECUTIVE COMMITTEE

DR. PEETER POLDRE

District 10 Representative
Toronto, Ontario

Principal Area of Practice or Specialty/Occupation:
Haematology/Internal Medicine

Elected Council Terms:
2012-2014
2014-2017

CPSO Committees/Positions Held and Other CPSO Work:

Discipline Committee:	2012-2014, Co-chair: 2014-2017
Executive Committee:	2016-2017
Governance Committee:	2015-2016
Policy Working Group: *Physicians' Relationships with Industry, Practice, Education and Research*	Chair: 2013-2014
Policy Working Group: *Continuity of Care and Test Results Management*	2016 - Present

STATEMENT:

My first half-year on the Executive Committee has been eventful. Bill 87 poses a significant challenge to the College and the profession. Physicians' roles in the opioid crisis will be a key issue for our future. And after almost two decades under the guidance of Dr. Gerace, the selection of a new Registrar is underway.

In addition to serving on Council, Governance and the Executive, I have been Co-Chair of Discipline for the last two years. I have also been a member of the Industry Relations and Continuity of Care working groups. These activities have given me a valuable perspective on the challenges facing the College. I have been fortunate during these efforts to work with many dedicated staff, members of Council and Committee members to collectively serve the public interest in our current ever-evolving environment. I have listened, learned, synthesized and then shared my views in what I hope has been a constructive, positive and forward-thinking manner.

As Vice President, I know that I will be well positioned to support the President and Executive Committee in the service of Council during this next year of transition.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, 2018 EXECUTIVE COMMITTEE

DR. BRENDA COPPS

District 4 Representative
Hamilton, Ontario

Principal Area of Practice or Specialty:
Family Medicine

Elected Council Terms:
2013-2016
2016-2019

CPSO Committees/Positions Held and Other CPSO Work:

Education Committee:	2015-2017
Governance Committee:	2016-2017
Quality Assurance Committee:	2013-2015, Co-chair: 2015-2017
Quality Assurance Working Group member:	2016
Policy Working Group: *Accepting New Patients/Ending the Physician-Patient Relationship*	2015 - Present
Policy Working Group: *Continuity of Care and Test Results Management*	2016 – Present, Chair
FMRAC Annual Meeting Delegate:	2015

STATEMENT:

Thank you for considering me for this important leadership position.

I have held past leadership roles at various levels of the health care system including terms as Chief of Family Medicine at St. Joseph's Hospital in Hamilton, and Chairman of the Board of the 150-member Hamilton Family Health team with its $20 million budget.

Here at the CPSO, I have further expanded my leadership skills and experience, in my capacity as Co-Chair of the Quality Assurance Committee and more recently, through my election to the Governance Committee and appointment as Chair of the Continuity of Care Policy Working Group.

At the same time, I am a generalist. As a family doctor, I prescribe opioids, guide patients at the end of their lives and grapple with continuity of care and access on a daily basis. I am intimately acquainted with the challenges of both patient and provider in delivering and receiving quality care.

I want to bring this ever important holistic yet comprehensive perspective to the executive team, where key policy and governance matters are considered before coming to Council.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2018 EXECUTIVE COMMITTEE

MS. LYNNE CRAM

Public Member of Council
London, Ontario
Occupation:

I retired in 2007 as Executive Vice President with Windjammer Landing Resort in St. Lucia. During my 16 years with the company, I lived in the Caribbean for 8 years and worked from Canada for the balance. Prior to Windjammer I enjoyed challenging careers with Xerox, Four Seasons and Hyatt Hotels. I am most proud of my community involvement in London for over 25 years. I am currently past Chair of Kings University College and have been on the board for 11 years. I have been on the Board of Goodwill Industries London for 7 years and am currently Vice Chair.

Appointed Council Terms:
2012-2018

CPSO Committees/Positions Held and Other CPSO Work:

Council Award Selection Committee:	2016-2017
Executive Committee:	2016-2017
Governance Committee:	2015-2016
ICR Committee:	2012-2017, Co-Vice Chair, General Panels 2016-2017
ICR Committee-Settlement Panel:	2015-2017
Outreach Committee:	2013-2015, Chair: 2015-2017
Joint Policy Working Group: *MD Relations with Drug Companies/Conflict of Interest: Recruitment of Research Subjects*	2013-2014
Policy Working Group: *Blood Borne Viruses*	2014-2015
Policy Working Group: *Physician Assisted Death*	2015-2016

STATEMENT:

Serving on the Executive Committee for the last half year continues to demonstrate that there is never a dull day at the CPSO.

Transparency, Sexual Abuse, MAiD and Narcotics continue to be major issues for both the Executive and Council. Recently there have been demands on the Executive to respond urgently and intelligently to the introduction of Bill 87, a bill that can have a major impact on our current structure. It seems inevitable that that status quo is not acceptable and we will be required to think strategically and outside the box, working with government to ensure that Bill 87 not only guarantees excellent health care but also allows CPSO to operate in a manner that is trusted by the public and government.

My work with ICRC gives me insight into many of the topics of discussion on Executive and I hope to continue to work collaboratively to build solution through policy development.

I look forward to being involved in the Registrar Selection Committee over the coming months and feel that continuity with the Executive is important as we transition to a new Registrar.

I request your support for my re-election to the Executive.

Thank you.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2018 EXECUTIVE COMMITTEE

MR. PIERRE GIROUX

Public Member of Council
Toronto, Ontario

Occupation:
Sales and Marketing

Appointed Council Terms:
2012-2016
2016-2019

CPSO Committees/Positions Held and Other CPSO Work:

Discipline Committee:	2013-2017
Executive Committee:	2015-2017
Finance Committee:	2013-2014, Chair: 2014-2017
Quality Assurance Committee:	2013-2017

STATEMENT:

In a working career spanning over forty years, I held senior management and executive positions in industry, government and banking. Those roles required several domestic and foreign relocations, including lengthy periods in Mexico City, Rome, Paris and London. Throughout these transfers, I learned the value of community, flexibility and self-reliance.

Since joining the College in 2012, I have been a vocal supporter of its mission; to ensure that the regulation and practice of medicine reflects and advances the interests, not only of those practising medicine, but also the public. I presently serve on three College Committees, Quality Assurance, Discipline and Finance, where I am currently the Chairman.

Since the beginning of 2016, I have been on the Executive Committee which has been a great learning experience. I believe I have been an engaged participant, not only reflecting the views and interests of the public members of Council, but also ensuring that balance and thoughtfulness are provided on all matters brought before the Executive Committee.

I am asking for your support for my re-election to the Executive Committee.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Memorandum

To	All Council Members
From	Dr. Joel Kirsh, Chair, and the Governance Committee
Date	April 10, 2017
Subject	Nomination/Election Process for the 2018 Executive Committee Vote at the May Council Meeting

---

At the May meeting of Council, an election will be held for the positions on the 2018 Executive Committee. The Committee consists of the President, Vice President, Past President, one physician member and two public members of Council.

As per the General By-Law, s. 39(1)(b), the immediate Past President is a member of the Executive Committee without the need to be elected to that position. If the immediate Past President is unwilling or unable to serve, there would be a vote for two physician members for the Executive Committee as per the General By-Law.

All Council members who wish to be nominated for a position on the Executive Committee are invited to submit an optional **Nomination Statement.** The Statement should be limited to 200 words. In addition, **Nomination Statements** will also include brief biographical information and the candidate's picture. N**omination Statements** will be emailed to all Council members and circulated, as an attachment, to the Governance Committee Report to Council.

Nomination Statements 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 an Executive Committee position.

In addition, to a **Nomination Statement**, a completed **Nomination Form** is due on the first day of the Council meeting at noon. Each Nomination requires the signatures of a nominator, a seconder, and the agreement of the nominee. Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.
Governance Process Manual

A chart identifying the current Executive Committee members is attached. I have also attached a sample **Nomination Statement** template, and the **Nomination Form(s)** for you to complete, should you wish to be nominated for a position on the 2018 Executive Committee.

A separate Council Contact List is also provided for you to facilitate communications between Council members.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Timeframe and Process for Executive Committee Nominations:

1. **If you wish to submit a Nomination Statement, please forward your request for your *personalized template* to Debbie McLaren at dmclaren@cpso.on.ca**

2. **The deadline for submission of your completed Nomination Statement is Monday, May 1, 2017 at 5 p.m. Nominations Statements that are submitted by the deadline will be circulated to all Council members and included with the Governance Committee Report to Council. Submitted Nomination Statements will be reviewed by the Chair of the Governance Committee, prior to circulation to Council.**

3. **The deadline for your completed Nomination Form *(with signature of nominee and 2 nominators)* is Thursday, May 25, 2017 at 12 noon.**

4. **Nominations from the floor will also be accepted during the Governance Committee Report on the day that the vote takes place.**

5. **The Executive Committee that is voted in at this meeting, will officially take office at the adjournment of the annual meeting of Council on December 1, 2017.**

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

Thank you,

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

att.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2017 EXECUTIVE COMMITTEE MEMBERS:

The Executive Committee composition is prescribed in the General By-Law. Council will vote for the President, Vice President, 1 physician member of Council and 2 public members for the 2018 Executive Committee at the May 2017 Council meeting.

Executive Committee Members	Length of Committee Appointment*	Current position and years on Committee
Dr. Steven Bodley	**2 years**	**Vice President 16/17** Physician Member 15/16
Ms. Lynne Cram	**1 year**	**Public Member 16/17**
Mr. Pierre Giroux	**2 years**	**Public Member 16/17,** 15/16
Dr. Joel Kirsh	**4 years**	**Past President 16/17** President 15/16 Vice President 14/15 Physician Member 13/14
Dr. Peter Poldre	**1 year**	**Physician Member 16/17**
Dr. David Rouselle - Chair	**3 years**	**President 16/17** Vice President 15/16 Physician Member 14/15

**[Length of Committee appointment reflects current term expiring on December 1, 2017]*

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR PRESIDENT:

I _____ am willing to be
Print name here
nominated for President.

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

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

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR VICE PRESIDENT:

I _____ am willing to be
Print name here
nominated for Vice-President.

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

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

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR PHYSICIAN MEMBER:

I _____ am willing to be
Print name here
nominated for Physician Member on the Executive Committee.

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

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

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

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR THE 2 PUBLIC MEMBERS ON THE EXECUTIVE COMMITTEE:
(You may nominate 1 or 2)

I _____ am willing to be
Print name here
nominated for Public Member on the Executive Committee.

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

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

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

Please fill out below for 2nd public member if you are nominating 2 public members.

I _____ am willing to be
Print name here
nominated for Public Member on the Executive Committee.

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

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

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

Public Council Presidents or Chairs **Appendix B**
April 2017

Have you ever had a public member from your Council or Board serve as College President?

a. If YES:
   - How often has this occurred?
   - What is the enabling process (e.g., a change in bylaws, regulations or legislation)? Council selects its own chair (president of Council) as allowed for in the Act

b. If NO:
   - Do you have the appropriate process in place to enable this?
   - If you do not, do you envisage making any changes in the near future to enable this?

MRA	Public President or Chair	Enabling Process (current or future)	Comments
CPSBC	No	Our HPA and bylaws support either a public member or an elected physician member serving as president. The president (chair) is elected by the board on an annual basis.	Look to the recent governance review done by the Ontario College of Nurses to see where the future lies.
CPSA	Yes – twice, including the current President.	Council selects its own chair (president of Council) as allowed for in the Act.	There was some reaction to the first public member president, none to the current appointment. It sends a great signal to the membership, government and the public about our 'public interest' focus.
CPSS	No	Public members are full members of the Council and may run for President or any other position on the executive in the yearly elections.	
CPSM	No	Bylaws currently prohibit.	Amendments to our legislation technically will permit but it is not anticipated that the bylaw requirements will change.

MRA	Public President or Chair	Enabling Process (current or future)	Comments
CMQ	No	No. Under the Code of professions and the Medical Act, only elected members of the Board can be candidates for President. All lay members are assigned by the Office of Professions and are not elected. Consequently, they cannot be candidates for presidency.	Strong culture of physician presidents.
CPSNB	No	A public member could become chair.	Public member chair is unlikely.
CPSPEI	No	Our legislation calls for the president of council to be a member of council.	
CPSNS	Yes	President-Elect is a public member. No by-law or legislative changes were required.	
CPSNL	Yes – twice, including the current President.	While the 'Act' may not directly speak to this scenario, it does not prevent it.	The 'Act' does stipulate that the Registrar and Deputy Registrar must be physicians.
Yukon	No	The requirement for a physician is currently enshrined in statute and has not been raised as an issue to date. Yukon's *Medical Profession Act* provides at ss. 3(1): The Commissioner in Executive Council shall appoint any member of the council who is a medical practitioner resident in the Yukon to serve at pleasure as chair of the council.	This is assuming "College President" equates to Chair of the Yukon Medical Council. The Government of Yukon – via the Registrar - and the Yukon Medical Council co-regulate the practice of medicine in Yukon.
NT	No	The *Medical Profession Act* sets out the composition of a Medical Registration Committee. Chair is a member of the Committee elected by committee members. There is no restriction – it could be any member of the committee.	To date, the chair of the Medical Registration Committee has always been a physician.
NU	N/A		

Ontario

Executive Council of Ontario
Order in Council

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

Conseil exécutif de l'Ontario
Décret

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

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*,

Roy Marra of Caledon

be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario for a period of three years, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6(1)b) de la *Loi de 1991 sur les médecins*,

Roy Marra de Caledon

O.C./Décret: 530/2017

est nommé au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour une durée fixe de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par: le ministre de la Santé et des Soins de longue durée

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

Approved and Ordered: MAR 0 8 2017
Approuvé et décrété le:

Lieutenant Governor
La lieutenante-gouverneure

Executive Council of Ontario/Conseil exécutif de l'Ontario **[Bilingual]**

Ontario

Order in Council
Décret

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

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

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*,

Judy Mintz of Toronto

be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario for a period of three years, effective the date this Order in Council is made.

- - - - - - -

EN VERTU DE l'alinéa 6(1)b) de la *Loi de 1991 sur les médecins*,

Judy Mintz de Toronto

O.C./Décret: 461/2017

est nommée au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour une durée fixe de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par : le ministre de la Santé et des Soins de longue durée

Concurred: Chair of Cabinet
Appuyé par : le président/la présidente du Conseil des ministres,

Approved and Ordered:
Approuvé et décrété le : MAR 0 1 2017

Lieutenant Governor
La lieutenante-gouverneure

Appendix D

2018 COMMITTEE INTEREST FORM
[2017-2018 COUNCIL TERM]

The Governance Committee follows Council's Nomination Guidelines in developing leadership and membership recommendations to Council. To assist the Governance Committee in its appointment of Councillors to committees for the 2017-2018 session of Council, please complete the form. A document entitled "College Committees" is attached to assist you in making your choices, as well as an Average Time Commitment Chart for Committee and Council Work.

In addition, please indicate whether you are interested in serving as Chair of that Committee in the column provided. The description of the role of a Committee Chair is attached for your information.

The Governance Committee reminds members of Council that it is often not possible to appoint members to every committee of their choice. In order to be considered for committee work, all Council members and committee members must sign the College's *Declaration of Adherence Form* that is contained in the Governance Process Manual. A *Criminal Record Check* must also be completed for all new Council members and all new non-Council committee members.

NAME: _____

Please mark your committee selections in the column that best describes your interest level and available time commitment. [Public members are asked to identify a preference for the Discipline Committee or the Inquiries, Complaints and Reports Committee].

Committee Name	Prefer Not to Serve on	Interested	Very Interested	Interested in Chairing this committee
Statutory Committees				
Discipline*	☐	☐	☐	☐
Fitness to Practise*	☐	☐	☐	☐
ICR*	☐	☐	☐	☐
Quality Assurance*	☐	☐	☐	☐
Registration	☐	☐	☐	☐
By-Law Standing Committees				
Council Awards**	☐	☐	☐	N/A
Education	☐	☐	☐	☐
Finance	☐	☐	☐	☐
Methadone	☐	☐	☐	☐
Outreach	☐	☐	☐	☐
Premises Inspection	☐	☐	☐	☐

Potential Committee Conflicts:
ICR committee members will not be appointed to the Discipline Committee and/or Fitness to Practise Committee or the Quality Assurance Committee and vice versa.
It is recommended that whenever possible, Quality Assurance Committee members are not members of the Discipline and/or Fitness to Practise Committee and vice versa.
****Council Awards Selection Committee is available to public members only, physician composition/chair selection is prescribed in the General By-Law.***
****Please complete the back of this form to outline your competencies to serve on the committees you have marked above, and if applicable, your competencies for chairing a committee.***

……continued on next page

Please note there is a nomination process and a council vote for the 2018 Executive Committee that will take place at the May 2017 Council meeting and a nomination process for the 2018 Governance Committee that will take place at the annual meeting of Council in December.

******COMMITTEE COMPETENCIES*:**

PLEASE STATE STRENGTHS, SKILLS, EXPERIENCE AND QUALITIES YOU WOULD BRING TO THE COMMITTEES YOU ARE INTERESTED IN SERVING ON.

******CHAIR COMPETENCIES*:**

PLEASE STATE THE STRENGTHS, SKILLS, EXPERIENCE AND LEADERSHIP QUALITIES YOU WOULD BRING TO THE POSITION OF CHAIR. IN WHAT DIRECTION WOULD YOU LEAD THE COMMITTEE?
PLEASE IDENTIFY ANY CURRENT PROBLEMS WITH THIS COMMITTEE AND YOUR IDEAS FOR SOLUTIONS.

GENERAL COMMENTS:

PRINT

COLLEGE COMMITTEES

Much of the work of the College is conducted through College committees. There are three types of committees. They include statutory committees, by-law committees and ad hoc committees and task forces.

Statutory committees are set out in the College's governing legislation, the Regulated Health Professions Act and the Medicine Act. They include:

- Discipline Committee
- Executive Committee
- Fitness to Practise Committee
- Inquiries, Complaints and Reports Committee
- Patient Relations Committee
- Quality Assurance Committee
- Registration Committee

Operating committees are set out in the College by-laws and are operational in nature. They include:

- Council Award Selection Committee
- Education Committee
- Finance Committee
- Governance Committee
- Methadone Committee
- Outreach Committee
- Premises Inspection Committee

Working groups/task forces are established to address specific issues. These groups are established by Council and are generally time limited and deal with a particular problem or issue.

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Committee Mandates

Discipline Committee

The Discipline Committee hears matters of professional misconduct or incompetence.

The Inquiries, Complaints and Reports Committee, after conducting an investigation, refer allegations to the Discipline Committee. A discipline panel is comprised of at least three members – two must be public members and one must be a physician member of Council. Panels are usually made up of four or five members.

If the panel finds that the physician has committed an act of professional misconduct or is incompetent, it can make an Order directing the Registrar to:

- revoke the physician's certificate of registration
- suspend the physician's certificate, and/or
- impose specified terms, conditions or limitations on the physician's certificate.

If the panel finds the physician has committed an act of professional misconduct, it can also make an Order:

- requiring the physician to appear before the panel to be reprimanded
- requiring the physician to pay a fine of not more than $35,000 to the Minister of Finance, and
- if the act of professional misconduct was the sexual abuse of a patient, requiring the physician to reimburse the College for funding provided for the patient for counselling and therapy, and requiring the physician to post security to guarantee payment.

If the panel finds the physician has committed an act of professional misconduct by sexually abusing a patient, the panel must:

- reprimand the physician, and
- revoke the physician's certificate if the sexual abuse consisted of or included certain acts.

In an appropriate case, the panel may also require the physician to pay all or part of the legal, investigation and hearing costs and expenses. The Discipline Committee also hears applications for reinstatement and motions to vary prior orders of the Committee.

Education Committee

The Education Committee reviews and makes recommendations to Council on matters of medical education in the province.

The Education Committee is responsible for:

- reviewing the undergraduate studies at faculties of medicine in Ontario and encouraging curriculum enhancement
- monitoring and sustaining the level and quality of Ontario postgraduate programs of medical education, and
- reviewing the Ontario continuing medical education programs.

Executive Committee
The mandate of the Executive Committee, as defined in the legislation, is to serve as the decision-making body of the College in between regular meetings of Council, and to report on these actions to the Council at subsequent Council meetings.
In acting on Council's behalf in between Council meetings, the Executive monitors and reviews policy issues under development and operational issues of significance.

Finance Committee
The Finance Committee is responsible for reviewing the financial affairs of the College and reporting directly to Council. It reviews such matters as investment policy, control of assets, the auditor's report, and the College's overall financial position.
The Finance Committee is directly and indirectly involved in reviewing and/or making recommendations to Council concerning any financial matter affecting the functioning of the College, including: the banking of the College's funds, investments, borrowing of monies, levels of approval and disbursement procedures relating to purchased goods and services, major items concerning the building, the findings of the external annual audit, the annual budget preparation and the remuneration paid to members of the College whole on College business. It also reviews the College's annual financial position.

Fitness to Practise Committee
The Fitness to Practise Committee conducts hearings of allegations concerning a physician's capacity to practise medicine that are referred by an incapacity inquiry panel of the Inquiries, Complaints and Reports Committee.

A Fitness to Practise panel is comprised of at least three members, and one member must be a public member of Council.

If the panel finds that the physician is incapacitated it can make an Order directing the Registrar to:

- revoke the physician's certificate of registration
- suspend the physician's certificate, and/or
- impose specified terms, conditions or limitations on the physician's certificate.

The College makes every effort to carefully balance the physician's rights with the protection of the public. The Fitness to Practise Committee also hears applications for reinstatement and motions to vary prior orders of the Committee.

Inquiries, Complaints and Reports Committee
The ICR Committee oversees all investigations into members' care, conduct and capacity, including complaints investigations, Registrar's investigations, and inquiries into members' capacity to practise.

The ICR Committee may be called upon to provide investigative direction to staff, and is required to dispose of investigations with a decision. Examples of decisions the ICR Committee may make include:

- requiring members to attend before a panel of the ICR Committee to be cautioned in person
- referring allegations of professional misconduct and/or incompetence to the Discipline Committee
- referring matters of incapacity to the Fitness to Practise Committee
- requiring members to complete a specified education or remediation program
- taking any other action which is not inconsistent with the legislation. (including taking no action and accepting members' undertakings)

A quorum of the ICR Committee consists of 3 members, including at least 1 member of Council appointed by the Lieutenant-Governor in Council. Panels of the ICR Committee may vary in size from 3 – 6 members. Several committee meetings are held monthly. These meetings consist primarily of reviewing documentary information relating to investigations, and by law are not open to members or the public.

Governance Committee
The Governance Committee monitors the governance process adopted by Council and develops Governance policies and practises to ensure an effective system of governance. It also recommends to Council changes to governance processes and oversees the nominations process. This includes making recommendations to Council regarding the membership and leadership of College committees. In addition, the Governance Committee nominates other officers, officials or other people acting on behalf of the College.

Methadone Committee
The Methadone Committee was established to oversee a program to improve the quality and accessibility of methadone maintenance treatment in the treatment of opioid dependence. The College actively manages the practise of methadone prescribing as a formal partner with the Mental Health & Addictions Branch of the Ministry of Health and Long-Term Care. The program receives full funding for all methadone registry, staff, physician assessments and other activities.

Outreach Committee
The Outreach Committee works with the Policy and Communications Division to help develop major communications and outreach initiatives to the profession and public. It also assists in the development of major communication and government relations strategies. In addition, it develops plans to deliver on each of the communications and outreach related components of the strategic direction.

Patient Relations Committee

The Patient Relations Committee advises Council with respect to the patient relations program. *The Regulated Health Professions Act* (RHPA) established that all Colleges must have a patient relations program that includes measures for preventing or dealing with sexual abuse of patients by members. The measures must include:

- educational requirements for members
- guidelines for the conduct of members with their patients
- training for the college's staff
- and the provision of information to the public. (The Health Professions Procedural Code, Schedule 2 to *The Regulated Health Professions Act* (S.84))

The committee is also responsible for administering a program of funding for therapy and counselling for persons who, while patients, were sexually abused by members.

Premises Inspection Committee

The Premises Inspection Committee is responsible for administering and governing the College's premises inspection program. The duties of the Committee are set out in the College's General By-law, and include:

- ensuring appropriate individuals are appointed to perform inspections and re-inspections;
- ensuring adequate inspections and re-inspections are undertaken and completed;
- reviewing premises inspection reports and other material and determining whether premises pass, pass with conditions or fail an inspection.

Quality Assurance Committee

The Quality Assurance Committee develops, establishes and maintains:

- programs and standards of practice to assure the quality of practice of the profession; and
- standards of knowledge and skill, and programs to promote continuing competence among physicians.

Registration Committee

The Registration Committee reviews the applications of physicians who wish to become members of this College, but do not fulfil the requirements for the issuance of a certificate of registration. After considering an application, the committee is charged with taking appropriate action within the powers granted to it under the law. The Registration Committee is also responsible for the development of policies and regulatory changes pertaining to registration requirements for entry to practice, whether they are for training programs or for independent registration.

AVERAGE TIME COMMITMENT FOR COMMITTEE AND COUNCIL WORK						*Revised: April 17, 2017*
Committee Name	**Number of meeting days/hearings days per year?**	**Preparation Time (per meeting/hearing)**	**Attendance at CPSO per meeting/hearing**	**Additional Teleconferences per year?**	**Decision/Report Writing Required for Committee Members?**	**Average approximate time commitment per meeting/hearing** *(includes prep and attendance at meeting)*
Council Award Selection Committee	1 (may be done by teleconference)	8 hours	¼ day	Not usual and rarely required	No	15 hours
Council Meetings ***(all Council members attend Council meetings)***	Two 2-day meetings Two 1-day meetings + 1-day *Annual Orientation Session for Council/committee members*	6 hours per 2-day meeting 3 hours per 1-day meeting	Two 2-day meetings Two 1-day meetings One day orientation = 7 days	Not usual, but sometimes required	No	18 hours per 2-day meeting 9 hours per 1-day meeting
Executive Committee	7	3 hours (additional 1-hour spent on emails prior to each Exec meeting)	1 day per meeting (6 hours)	As required	No	3 hours per Executive meeting + ? hours for teleconferences
Discipline Committee	20 to 80 hearing days 150 days scheduled that are cancelled due to settlement Payment for late cancellation (<10 business days' notice) 2 days of business meetings 2 to 3 days of education	0 to 4 hours for meetings 0 prep for most hearings 2 to 6 hours for motions 2 to 6 hours for closing submissions	1 day up to 5 to 10 days a month 70% of hearings proceed on an uncontested basis and complete in ½ day Contested hearings range from 3 days to several weeks Lengthy hearings are booked with 1 to 3 weeks in between in each hearing week There is an expectation that committee members commit to as many hearings panels as their schedules permit, including lengthy hearings. Active members commit to 70 to 80 days per year and, due to cancelled days, sit for 30 to 50 hearing days per year. Others commit to 8 to 18 days and sit for 5 to 15 days per year.	Sometimes required for motions or panel deliberation	Yes One person on the 5-person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours *(could be more depending on hearing)*

Education Committee	5	3 hours	3 half-day meetings 2 full-day meetings	No	No	9 hours
Finance Committee	3	2 hours	1 full-day	Not usual, but sometimes required	No	6 to 8 hours
Fitness to Practise Committee	Hearings rarely occur - 1 to 5 days for a hearing is possible 10 days scheduled that are cancelled due to late settlement Payment for late cancellation (<10 business days' notice) ½ day business education meeting	0 to 4 hours for meetings 0 prep for most hearings 2 to 6 hours for motions	Hearings rarely proceed as cases tend to resolve with health and practice monitoring agreements Uncontested hearings complete in ½ day Contested hearing when they occur, range from 3 to 5 days	Rare. Hearings are closed to the public, so may proceed by teleconference if uncontested.	Yes. One person on the 3-person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours
Governance Committee	5	3 hours (8 hours for 1 nominations meeting)	½ day 1 full-day meeting for committee nominations	2 x 2 hours (as required)	No	4 to 11 hours
Inquiries, Complaints and Reports Committee ***(Note: Individual members are not required to participate in all ICRC meetings.)***	***For total committee:*** 24 General Panels (a non-panel Chair could attend on average 4 - 6 panels per year) 50 Specialty Panels (a non-panel Chair could attend on average 6-8 panels per year)	***Prep Per Meeting:*** General Panels average 36 to 48 hours or 6-8 days prep (1 day = 6 hour periods) Specialty Panels average 24 - 30 hours or 4-5 days prep (1 day = 6 hour periods)	***Attendance Per Meeting:*** General Panel meetings: ½ day - 1 day (x 4 – 6 per year) Specialty panels: ½ day (x 6-10 per year)	***Assignments rotated for a quorum of 3 members.*** Teleconferences 40 x 1 hour weekly Ad-Hoc as required 24 x 1 hour as needed Medium Track: 12 x 2 hours monthly. Fast Track: 24 x 1 hour twice a month Settlement: 24 x 2 hours twice a month	Need to review cases in advance of meeting and submit "Members' notes and decision reasoning"; Panel Chairs need to review and approve decisions from their assigned meetings.	General Panel Meeting: 39 to 54 hours Specialty panels: 27 - 33 hours Weekly Teleconferences: 6 hours Medium Track: 12-15 hours Fast Track: 3-6 hours Settlement: 6 hours

Inquiries, Complaints and Reports Committee (continued)	40 Verbal Caution panels (with attendance for 4-6 half days per year) 24 Health inquiry panels meetings (a non- panel Chair could attend 12 half days per year) 2 days yearly to discuss Business and Policy matters relating to member specific issues (with attendance at 2 days per year)	Verbal caution panels: Approx. 2 hours Health inquiry panels: Approx. 3-6 hours Business meetings: Approx. 2-3 hours	Verbal caution panels: ½ day (x 4 - 6 per year) Health inquiry panels: 2 hours (x 12 per year) Business/Policy meetings: 1 day (x 2 per year)			Verbal caution panels: 5 hours Health inquiry panels: 6-8 hours Business/Policy meeting: 8-9 hours
Methadone Committee	Participation in 1-day orientation session There are six 1-day meetings per year Attendance suggested at the *CPSO Annual Prescribers' Conference*	3 hours	Full Day	Not usual, but sometimes required *(max. of 3)*	No	9 hours
Outreach Committee	3 to 4 half-day meetings per year	1 to 2 hours	½ day	No *(Note: Committee members have the option to participate on meetings by teleconference)*	No	4 ½ to 5 ½ hours
Patient Relations Committee	1 meeting + 7 to 8 teleconference meetings	1.25 hours	1 day	7 to 8 1 hour to 1.25 hour teleconferences	No	1½ to 3 hours

Premises Inspection Committee	Estimate 2½ days and 2 full days business/policy meetings - Estimate 6 + panel meetings per year (by teleconference)	Up to 10 hours to review premises reports and submissions	2 -full days for policy meetings 2 -½ day policy meetings	Possibly extra meetings held by teleconference for review of urgent cases	No (Completed by Program Decision Writer)	Up to 12 hours
Quality Assurance Committee (meets in panels)	Participation in 1-day orientation session Five 1-day Policy meetings 1-day Education meeting Commitment to participate in a minimum of 5-6 member specific issue (MSI) meetings per year	9-12 hours for member-specific panel meetings	Full Day	Commitment to be available for teleconferences resulting from complex cases (# varies each year). Teleconferences generally scheduled for early morning or end of day.	No	19 hours
Registration Committee	10 days for MSI and 2 days for policy meetings - 12 panel meetings per year	12-16 hours	1 day	None	No	20 to 24 hours

Committee Chair

Reports to (Title): Council

Administratively to President

Updated: February 2010

Overview:

There are three types of committees that perform the work of the CPSO. These are comprised of statutory committees (i.e., Executive, Complaints, Discipline, Fitness to Practise, Registration, Patient Relations, and Quality Assurance), standing or operational committees (i.e., Education, Methadone, Governance, Outreach, Premises Inspection, and Finance) and ad hoc committees that are created by Council to undertake a particular project on behalf of the College on a time-specific basis. The role of the Committee Chair has some commonly held responsibilities that transcend specific committee mandates.

Chairs must be knowledgeable about the subject matter of the committee they lead and have the expertise necessary to fulfill its mandate. The Chair must understand the purpose of the committee, provide leadership to the committee to achieve its goals in a consistent, efficient, and balanced manner, and organize the committee's work so that action is taken in an orderly and timely manner. The Chair reports the work of the committee to Council and facilitates Council's understanding of this work. All Chairs are responsible for assessing whether their committee members have the resources and training to perform effectively in order to deliver on the mandate of the committee.

Major Responsibilities:

Leadership and Direction of the Committee

- Is knowledgeable and supportive of Council policy, and the work and responsibilities of the committee. Is knowledgeable about the regulatory and statutory obligations of the committee and CPSO.
- Read and become familiar with the College's By-laws and governance policies.
- Where applicable, works collaboratively with the other Chair to accomplish the work of the committee. If the other Chair is a non-Council committee member, they keep him or her informed of Council decisions and changes that occur.
- Adhere to, respect and model behaviour described in the Statement on Public Interest, Council Code of Conduct, Conflict of Interest Policy, Apprehension of Bias Policy and Confidentiality Policy.
- Works with the Committee and College staff to establish, monitor, and execute annual committee goals.
- Prepares for committee meetings by reviewing materials. Works with assigned staff in support of the successful fulfillment of the committee's mandate.

- Conducts meetings in a timely and cost effective manner, and facilitates the meeting process so that all members have the opportunity to participate and accept tasks that best meet their skills and interests.

- Facilitates dialogue at committee meetings in a manner that welcomes all members' perspectives on issues, encourages independent thinking, promotes alignment on decisions that are balanced and demonstrate good judgment for the successful fulfillment of the committee's purpose.

- Manages conflict effectively. When necessary, brings matters to the attention of the Registrar and President.

- Demonstrates cultural sensitivity in policy development, policy implementation, and communications, and personally models behaviours described in the Council's Code of Conduct.

- Obtains appropriate expertise pertinent to the committee's work to provide a synthesis of information that identifies important issues for discussion or requiring action to efficiently expedite the committee's work.

- Understands the relationship of the various activities of the College committees to facilitate decision-making and to provide clarity around responsibility.

- Ensures new committee members understand the purpose and functions of the committee. Helps to facilitate the succession process by working with the Governance Committee to recruit new committee members and subsequent committee Chairs.

- Evaluates the committee's performance of its duties and works to implement improvements to ensure its continued effectiveness. Provides feedback to the Governance Committee on the performance of committee members annually.

- Enforces attendance guidelines with committee members to ensure that if more than three consecutive meetings are missed or if one third of all meetings within the year are missed that a member's continued involvement with the committee is reviewed.

- Ensures that the committee provides feedback to the Governance Committee on the Chair's performance. Participates in self-evaluation with the President to obtain feedback on own and committee's performance.

Collaborative Linkage between the Committee and the College Management Staff

- Works in cooperation with College management and staff to ensure appropriate utilization of College resources in support of the committee's work.

- Works in cooperation with College management in the development of the committee's annual budget to allocate costs and expenses in a fiscally responsible manner.

Key Representative of the Committee

- Is the spokesperson for the committee to Council and within the College and ensures that Council is informed and understands the rationale for decisions made by the committee in the fulfillment of its mandate.

Role Outcomes:

- Uphold policies and standards of the College in the fulfillment of committee duties.
- Decisions comply with appropriate legislation and CPSO policies.
- Reports to the College Council are made, as required, representing committee activities.
- Risk as it relates to the committee's mandate is managed, and Council is alerted to pertinent issues in a timely manner.
- New policies are recommended to the Council, as required.
- Committee members are evaluated to support and promote the improvement of committee effectiveness.
- Interaction with College staff occurs by provision of information regarding the committee's work. Interaction with staff is managed in a respectful, collegial manner.

How far in advance must this position plan/execute its work? (i.e., daily, weekly, monthly, annually or longer)

- Preparation and attendance time is dependent on the nature and tasks of the committee (see Committee descriptions for more details).

Principle Interfaces:

Internal:	Council Committee Chair Committee members College staff Council
External:	Dependent on the mandate of the Committee

Desirable Behavioural Competencies

Key behavioural competencies that are essential for successfully performing this role:

Continuous Learning – Involves taking actions to improve personal capability, and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity – Is generating new solutions, developing creative approaches and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication – Is willing and able to see things from another person's perspective. Demonstrates the ability for accurate insight into other people's/group's behaviour and motivation, and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Leadership – Is the ability to take a role as leader of the Council or Committee. Creates strong morale and spirit in his/her team. Shares wins and successes. It includes demonstrating a positive attitude, energy, resilience, stamina and the courage to take risks. Integrity is recognized as a basic trait required.

Planning & Initiative - Recognizes and acts upon present opportunities or addresses problems. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building – Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Council-related goals and the College mission.

Results Oriented – Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality, stakeholder satisfaction; revenues; etc.).

Stakeholder Focused – Desires to help or serve others, meets the organization's goals and objectives. It means focusing one's efforts on building relationships, and discovering and meeting the stakeholders' needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders needs.

Strategic Thinking – Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

Teamwork – Demonstrates cooperation within and beyond the Council or the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly, and adapts tactics to situations or to others' response. Can accept set-backs and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: Accepting New Patients – Consultation Report and Revised Draft Policy

FOR DECISION

ISSUE:

- The draft *Accepting New Patients* policy was released for external consultation following the December meeting of Council.
- Council is provided with a report on the feedback received during the consultation period, and proposed revisions made by the Working Group in light of this feedback.
- Council is asked whether it approves the revised draft *Accepting New Patients* policy (attached as Appendix 'A') as a final policy of the College.

BACKGROUND:

- The *Accepting New Patients* policy was first approved by Council in September 2008 and last updated in 2009. The policy is currently under review in accordance with the CPSO's regular policy review cycle.
- 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 joint Working Group has been struck to lead the review of the *Accepting New Patients* policy, along with the review of the *Ending the Physician-Patient Relationship* policy. This joint working group is chaired by Dr. Michael Franklyn, and comprised of Dr. Brenda Copps, Mr. John Langs, Mr. Arthur Ronald, and Dr. Lynne Thurling. The Working Group is supported by Dr. Angela Carol (Medical Advisor) and Jessica Amey (Legal Counsel).
- The policy review process has been informed by an extensive research review, which included: a comprehensive literature search; a jurisdictional comparison of guidance on accepting new patients provided by medical regulators and medical

associations, both within Canada and abroad; a preliminary consultation on the current policy; as well as a public poll of a representative sample of Ontarians.

- Based on research undertaken, feedback received during the preliminary consultation, and public polling results, the Working Group developed the draft *Accepting New Patients* policy. The draft policy was approved for external consultation at the December 2016 meeting of Council.

CURRENT STATUS:

a) Report on Consultation

- Broadly speaking, the nature and tone of the feedback received in response to the draft *Accepting New Patients* policy was thoughtful, constructive and frequently positive, with suggestions for revision focusing on a few core issues.

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 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 a brief online survey, or by posting comments to the consultation-specific webpage.

- The consultation was held from December 12th, 2016 until February 10th, 2017.

Number of responses

- In total, 108 submissions were received in response to this consultation. This included 60 comments either submitted by mail or posted to the online discussion page and 48 online surveys.

- Approximately 78% of respondents identified themselves as physicians, 11% as members of the public, 5% as "other" or "unidentified", and 6% as organizations.[1]

[1] The organizations that submitted written feedback included: The Ontario Medical Association (OMA); Health Care Connect Provincial Care Connectors; The Professional Association of Residents of Ontario (PARO); and The Ontario Medical Association (OMA) Section on General Family Practice. In addition, The College of Physicians and Surgeons of Alberta and the North Simcoe Muskoka Community Care Action Centre (CCAC) completed surveys.

b) Feedback Received

- Stakeholder feedback has been posted publicly on the consultation-specific page of the College's website.[2]

General Comments

- Regarding the clarity of the draft policy, the vast majority of survey respondents agreed that the policy is easy to understand (90%), clearly written (91%), clearly articulates physicians' professional obligations (85%), and is well organized (85%).

- When asked about the comprehensiveness of the draft policy, respondents were more divided. Approximately 58% of survey respondents agreed that the policy addresses all important issues relating to accepting new patients into primary care, and 62% felt that that the draft policy addresses all important issues relating to specialty care.

- The main concerns pertaining to comprehensiveness are elaborated upon in the issue-specific comments described below. Namely, some respondents indicated that the draft policy does not take into account the triaging of referrals where urgent care is required, and does not address physicians' right to accept new patients in a manner that facilitates a balanced practice.

- As in the preliminary consultation, many respondents expressed support for the policy requirement that physicians accept new patients on a first-come, first-served basis, particularly as a means to prevent discrimination. This support was again illustrated in survey results: approximately 77% of survey respondents agreed that the first-come, first-served approach helps physicians to satisfy their legal obligations under the Ontario *Human Rights Code*.

Key Issue-Specific Comments

Physicians' discretion to make decisions regarding their patient population

- Despite broad support for the first-come, first-served approach, a number of physician respondents commented that they should have the ability to accept new patients in a manner that facilitates a balanced practice. This feedback was raised particularly with respect to physicians who feel that they do not have the capacity to accept higher-need and/or complex patients.

- As in the preliminary consultation, some physician respondents felt that they should have the ability to refuse patients who already have a family physician. Physicians

[2] A complete summary of survey feedback is not yet available. A survey report will be posted alongside the written feedback once finalized.

who shared this perspective noted that in a limited resource environment, patients without family physicians should be prioritized. On the other hand, some respondents supported a patient's ability to change health care providers, for instance due to dissatisfaction with the care being provided.

Use of introductory meetings and medical questionnaires when accepting new patients

- Consultation participants generally agreed that introductory meetings and medical questionnaires should not be used as a means to vet prospective patients that are perceived to be more desirable.

- Many respondents, however, pointed to instances where introductory meetings and medical questionnaires are appropriate in the course of establishing an effective physician-patient relationship. For instance to ensure that the terms of the relationship are acceptable to the patient. This sentiment was echoed in the survey where respondents indicated that the draft policy would benefit from further clarity around the circumstances where the use of introductory meetings and medical questionnaires would be appropriate.

Clinical competence and/or scope of practice

- Consultation respondents generally expressed support for the requirement that physicians not use clinical competence and/or scope of practice as a means of discriminating against prospective patients. Some felt that this expectation should be further emphasized. The Health Care Connect Provincial Care Connectors[3], for instance, suggested that this expectation appear earlier in the policy.

- The vast majority of survey respondents agreed with the professional obligations set out in the draft policy where a physician refuses a prospective patient due to clinical competence and/or scope of practice. Specifically, 85% agreed that the reasons for the refusal must be clearly communicated to the patient, and 83% agreed that the physician must take steps to ensure that the individual understands that the refusal is not based on discriminatory bias or prejudice.

- The OMA Section on General Family Practice (SGFP) commented that family physicians should be able to decline prospective patients if they feel they do not have the requisite experience or supports to handle particularly complex, vulnerable patients.

[3]Health Care Connect is a Ministry of Health and Long Term Care program that refers Ontarians who don't have a physician to a family health care provider who may be accepting new patients. Care Connectors work closely with patients and physicians to facilitate referral to a provider. The feedback received was from the perspective of the Care Connectors, based on their experience and observations working within their scope and role as Care Connectors. The feedback provided by the Care Connectors represents their perspective, and not that of the broader organization, the Ontario Ministry of Health and Long Term Care, or the Community Care Access Centres for which they work.

Application of policy to physicians who provide specialty care

- Approximately 62% of survey respondents felt that the draft policy addresses all important issues relating to accepting new patients for specialty care. Further, a slight majority of respondents (56%) felt that the policy clearly articulates how the first-come, first-served approach applies to physicians who provide specialty care (56%).

- Those who felt that the draft policy does not sufficiently address all of the important issues relating to accepting new patients for specialty care, focused on how the first-come, first-served approach is to be reconciled with specialists' frequent need to triage patients requiring urgent care. These respondents indicated that further clarity was needed in this regard.

Physicians' obligations where a patient is not accepted

- Less than half of survey respondents (44%) felt that the expectation set out in the draft policy, requiring physicians to provide patients with a referral for those elements of care that they are unable to manage directly, was a reasonable one.

- Despite not being the intention of the draft, it is evident from the feedback received that many respondents interpreted this requirement to mean that a physician, who had not accepted a patient into their practice, would be responsible for finding the patient an alternative healthcare provider.

- In light of this misunderstanding, many commented that such a requirement would be burdensome and unrealistic, particularly for specialists.

Accepting Family Members of Current Patients

- The draft policy includes an exception to the first-come, first-served approach to allow physicians providing primary care, with otherwise closed practices, to accept the family members of current patients.

- A strong majority of survey respondents (88%) felt that this exception was appropriate, and that caring for the family members of current patients supports the provision of quality care (81%).

- Other respondents, however, felt that it is inappropriate to make exceptions for family members of current patients because of, for example, concerns associated with maintaining confidentiality among family members; the potential burden on the physician; and the facilitation of queue jumping.

c) Revisions in Response to Feedback

- All of the feedback received was carefully considered by the Working Group. The revisions proposed by the Working Group have been incorporated into the revised draft policy, attached as Appendix 'A'. Key revisions are highlighted for Council's reference below.

- Overall, the revised draft policy retains the key content and central principles of the draft policy that was released for consultation. While the changes made are not substantive, the revised draft includes updates primarily to enhance the clarity of the document.

Key Revisions and Additions

Physicians' discretion to determine whether their practice is closed

- The Working Group felt it appropriate to clarify that the first-come, first-served approach does not prevent physicians from determining when their practice is "closed" and not accepting new patients.

- Content has been added at Line 73 to signal that the first-come, first-served approach does not prevent physicians from making such determinations; however, physicians must do so in good faith.

Appropriate uses of introductory meetings and medical questionnaires

- The revised draft policy maintains the requirement that introductory meetings and/or medical questionnaires not be used to vet prospective patients.

- In response to feedback that there are also appropriate uses of introductory meetings and medical questionnaires, content has been moved from a footnote to the body of the policy (Line 82). Specifically, the body of the policy now states that introductory meetings and medical questionnaires may be appropriately used after a patient has been accepted into the physician's practice to, for instance, identify a new patient's needs and expectations, and to determine whether the terms of the physician-patient relationship are acceptable to the patient.

Obligations with respect to clinical competence and/or scope of practice

- As mentioned, consultation respondents commented that the policy should more clearly state that clinical competence and/or scope of practice must not be used as a means to discriminate against prospective patients.

- In response to this feedback, this expectation is now also highlighted earlier in the draft policy at Line 53.

Application of policy to specialists

- In order to enhance clarity regarding the application of the policy to specialists, content has been added at Line 151 to signal that a departure from the first-come, first-served approach may be required to triage patients with urgent health care needs.

Physicians' obligations where a patient is not accepted

- In light of feedback received, the Working Group sought to clarify the requirement in the draft policy that physicians refer patients to another appropriate health care provider for those elements of care they are unable to manage directly.

- This requirement has been reworded at line 136 to clarify that the referral expectation is only activated where a family physician has already accepted a patient into their practice, and is unable to manage certain elements of that patient's care due to their own clinical competence and/or scope of practice. In such circumstances, the physician must provide the patient with a referral for those elements of care that the physician is unable to manage directly. The referral requirement *does not* apply where a patient has not been accepted into a physician's practice.

- In the specialist context, there are circumstances where specialists are unable to accept a referral due to their own clinical competence or scope of practice. In such circumstances, the revised draft policy recommends that specialists, where possible, provide the referring health-care practitioner with suggestions for alternative care provider(s) who may be able to accept the referral (Line 157).

d) Revisions not made in response to feedback received

- The Working Group has maintained the exception to the first-come, first-served approach that permits physicians providing primary care, with otherwise closed practices, to accept the family members of current patients. The Working Group felt strongly that caring for patients and their family members is important for the provision of quality care.

- The Working Group has not added an exception to the first-come, first-served approach to allow for the prioritization of patients without a family physician. This is in keeping with 'Principle 3' set out in draft policy, namely that patient autonomy and freedom of choice of health-care provider be respected (Line 25).

NEXT STEPS:

- Should Council approve the draft policy, as revised, it will be published in *Dialogue* and will replace the current version of the policy on the CPSO website.

DECISION FOR COUNCIL:

1. Does the Council have any feedback on the revised draft *Accepting New Patients* policy?

2. Does Council approve the revised draft policy be forwarded to Council to be considered for final approval?

Contact: Dionne Woodward, Ext. 753
Tanya Terzis, Ext. 545

Date: May 5, 2017

Attachments: Appendix A: Revised Accepting New Patients policy

Accepting New Patients

INTRODUCTION

Physicians must accept new patients in a manner that is fair, transparent, and respectful of the rights, autonomy, dignity and diversity of all prospective patients. Doing so reinforces public trust in the profession, and fosters confidence in the physician-patient relationship.

This policy sets out physicians' professional and legal obligations when accepting new patients. Physicians satisfy these obligations, in part, by accepting new patients on a first-come, first-served basis. Doing so helps to ensure compliance with the Ontario *Human Rights Code*, which entitles every Ontario resident to health services free from discrimination.

PRINCIPLES

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

1. Acting in the best interests of prospective patients by ensuring that decisions to accept new patients are equitable, transparent and non-discriminatory.
2. Communicating effectively and respectfully with prospective patients in a manner that fosters trust in the profession and supports the establishment of a trusting physician-patient relationship.
3. Respecting patient autonomy and a patient's freedom of choice of health-care provider.
4. Managing conflicts with compassion and sensitivity, especially where the physician's values differ from the values of the prospective patient.
5. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

SCOPE

This policy applies to all physicians, and those acting on their behalf[1], regardless of practice area or speciality, any time they accept new patients into their practice. Specifically, this policy applies both where physicians, by nature of their practice, would typically establish:

- A longitudinal physician-patient relationship characterized by repeated clinical encounters;[2] or
- A physician-patient relationship that exists for a defined time period.[3]

[1] For instance, physicians may rely upon clinical managers and/or office staff to accept new patients on their behalf. Organizations may also act as a physician's representative in this context.

[2] For instance, the relationship typically established between a patient and their primary care provider.

[3] For instance, a relationship established between a patient and a physician providing specialty care for a specific condition over a finite time period.

POLICY

Physicians must employ the first-come, first-served approach when accepting new patients into their practices. This approach, which is set out below, helps to ensure that all patients receive equal treatment with respect to health services, as required under the Ontario *Human Rights Code*.

This policy begins by describing the first-come, first-served approach, and explains its rationale. The policy details how this approach applies in circumstances where physicians:

- Limit their practices due to clinical competence, scope of practice and/or a focused practice area;[4]
- Provide speciality care; and/or
- Maintain a waiting list of prospective patients.

The policy sets out physicians' obligations where their clinical competence and/or scope of practice does not align with the patient's care needs. The policy emphasizes that clinical competence and/or scope of practice must not be used as a means of discriminating against prospective patients.

The College acknowledges that there are circumstances where physicians are justified in prioritizing access to care for those most in need. These limited exceptions are set out below.

First-Come, First-Served Approach

The College expects physicians, and those acting on their behalf, to follow the first-come, first-served approach when accepting new patients. This means that physicians, who are accepting new patients, must do so on a first-come, first-served basis, when the patient's needs are within:

- The physician's clinical competence and/or scope of practice;
- The physician's focused practice area; and/or
- The terms and conditions of the physician's practice certificate and associated practice restrictions, if applicable.

The first-come, first-served approach does not prevent physicians from making decisions about whether their practice is accepting new patients. Such decisions must be made in good faith.

It is counter to the first-come, first-served approach, and therefore inappropriate, for physicians, or those acting on their behalf, to use introductory meetings such as 'meet-and-greet' appointments, and/or medical questionnaires to vet prospective patients and determine whether to accept those patients into the practice.[5] Doing so may be considered discrimination against prospective patients.[6]

[4] Physicians with a 'focused practice area' may include those with a commitment to one or more specific clinical practice areas, or who serve a defined target population.

[5] Medical questionnaires include those administered in person, by phone, or electronically by physicians or those acting on their behalf.

[6] The Human Rights Tribunal of Ontario has primary responsibility for investigating and adjudicating claims of discrimination.

However, once a patient has been accepted into a physician's practice, physicians may use introductory meetings and/or medical questionnaires to share information about the practice and/or obtain information about the patient. For instance, introductory meetings and/or medical questionnaires may be helpful to identify a new patient's needs and expectations, to disclose information about the physician's knowledge area, to advise of after-hours coverage, or to determine whether the terms of the physician-patient relationship are acceptable to the patient. Further, introductory meetings may involve establishing expectations regarding adherence to a prescribed therapy. This may include, for instance, establishing a treatment agreement (e.g. narcotics contract) between the physician and the patient.

Rationale for the First-Come, First-Served Approach

The first-come, first-served approach helps to ensure that physicians fulfill their legal obligations under the Ontario *Human Rights Code* (the '*Code*'). The *Code* entitles every Ontario resident to equal treatment with respect to services, goods and facilities, without regard to race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Under the *Code*, all those who provide services in Ontario, including physicians providing health services, must do so free from discrimination on any of the above-listed grounds. In keeping with this legal obligation, physicians must not refuse prospective patients based on any of the prohibited grounds of discrimination.[7]

Applying the First-Come, First-Served Approach

i. Clinical Competence, Scope of Practice and Focused Practices

Physicians may limit the health services they provide based on their own clinical competence and/or scope of practice. Further, some physicians have limited or focused practices based on specific clinical areas such as geriatrics, psychotherapy or adolescent health.

If a patient's care needs do not align with the physician's clinical competence and/or scope of practice, this would be permissible grounds for refusing a prospective patient. Similarly, if a patient's care needs do not align with the physician's focused practice area, this would also be permissible grounds to refuse to accept a patient into the practice. Such decisions, however, must be made in good faith.

Physicians, and those acting on their behalf, must not use clinical competence and/or scope of practice as a means of discriminating against patients as defined by law, or to refuse patients:

- With complex or chronic health needs;
- With a history of prescribed opioids and/or psychotropic medication; [8]
- Requiring more time than another patient with fewer medical needs; or

[7] For more information see the College's *Professional Obligations and Human Rights* policy.

[8] Physicians are advised to consult the College's *Prescribing Drugs* policy for further information on the College's position on blanket 'no narcotics' prescribing policies.

- With an injury, medical condition, psychiatric condition or disability[9] that may require the physician to prepare and provide additional documentation or reports.

Where a physician refuses a patient based on clinical competence, scope of practice, and/or a focused practice area, the physician must consider the impact on the patient. Such refusals can result in patients experiencing discrimination in the provision of care, even where this is not the intention of the physician. Physicians must clearly communicate the reasons for the refusal to the patient. This is to ensure that the individual understands that the refusal is not based on discriminatory bias or prejudice.

Physicians with primary care practices are reminded that given their broad scope of practice, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient. Once a patient is accepted into a primary care practice, should elements of the patient's health care needs be outside of the physician's clinical competence and/or scope of practice, the patient must not be abandoned. In such circumstances, the College requires that the patient be provided with a referral to another appropriate health-care provider for those elements of care that the physician is unable to manage directly.

ii. Specialist Care

The expectations set out in this policy apply to all physicians, including those who provide specialist care. The College recognizes that the process by which a patient is accepted into a specialist's practice is distinct from that applicable to primary care. This process will typically involve a referral from another physician or health-care provider.

The College expects specialists to employ the first-come, first-served approach by accepting new patients in the order in which the referral was received. Departing from this practice is appropriate only to accommodate patients requiring priority access to care. This may mean, for instance, triaging patients with urgent health care needs.

Where a referral is outside of the specialist's clinical competence or scope of practice, the specialist must promptly communicate this information to the referring health care practitioner, and/or patient where appropriate, to facilitate timely access to care. Where possible, the College recommends that specialists provide the referring health care practitioner with suggestions for alternative care provider(s) who may be able to accept the referral.

iii. Waiting Lists

Some physicians maintain a waiting list of prospective patients. Where this practice is employed, the first-come, first-served approach continues to apply in relation to all patients

[9] Physicians should be aware that under the *Code*, the term 'disability' is interpreted broadly and covers a range of conditions. 'Disability' encompasses physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions. The *Code* protects individuals from discrimination because of past, present and perceived disabilities.[9]

who have been noted on the list. Wait-listed patients are to be accepted into the physician's practice in the same order in which they were added to the list. Physicians are advised to use waitlists cautiously, and to manage patient expectations by clearly communicating the expected waiting period.

Potential Exceptions to First-Come, First-Served Approach

i. Accepting Higher-Need and Complex Patients

There are circumstances where it may be appropriate for physicians to prioritize access to care for higher-need and/or complex patients. Patients who may be categorized as higher-need and/or complex include, but are not limited to, those requiring urgent access to care, those with chronic conditions, particularly where the chronic condition is unmanaged, an activity-limiting disability and/or mental illness.

Any decision to prioritize a patient's access to care must be made in good faith. Physicians must use their professional judgement to determine whether prioritization based on need is appropriate. In doing so, physicians must take into account the individual patient's health-care needs, and any social factors, including education, housing, food security, employment, and income, that may influence the patient's health outcomes.

ii. Caring for Patients' Family Members

In the context of primary care, there may be times where a physician is asked to accept the family members of current patients. The College acknowledges that caring for patients and their family members may assist in the provision of quality care. Caring for family members, for instance, may help the physician to have a clearer picture of family history, which may in turn contribute to better health outcomes for the patient. Accordingly, where a physician's practice is otherwise closed, physicians may choose to prioritize access to care for the family members of current patients.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: Ending the Physician-Patient Relationship – Consultation Report and Revised Draft Policy

FOR DECISION

ISSUE:

- The College's *Ending the Physician-Patient Relationship* policy is currently under review in accordance with the regular policy review cycle.
- A Working Group consisting of public and physician members of Council has been struck to undertake this review, and has developed an updated policy which was circulated for external consultation between December, 2016, and February, 2017.
- Council is provided with a report on the consultation feedback received, and an overview of the proposed revisions to the draft policy.
- Council is asked whether the revised draft *Ending the Physician-Patient Relationship* policy can be approved as a policy of the College.

BACKGROUND:

- The College's *Ending the Physician-Patient Relationship* policy is currently under review in accordance with the regular policy review cycle.
- The policy, which was originally approved by Council in 2000, and last updated in 2008, sets out key principles and expectations for physicians when ending the physician-patient relationship for any reason other than the physician's retirement, relocation, leave of absence, or as a result of disciplinary action by the College.
- A policy Working Group has been struck to undertake this review. The members of the Working Group are Dr. Michael Franklyn (Chair), Dr. Brenda Copps, Mr. John Langs, Mr. Arthur Ronald, and Dr. Lynne Thurling. Staff support has been provided by Jessica Amey (Legal Counsel) and Dr. Angela Carol (Medical Advisor).

- This Working Group is simultaneously undertaking a review of the College's *Accepting New Patients* policy, as both policies address inter-related issues of professionalism, patient access, and balancing the best interests of physicians and patients.

- During the initial stages of this review, the Working Group undertook extensive research into the central issues related to ending the physician-patient relationship. This included a comprehensive literature review, consideration of the positions taken by other key stakeholders, including those of other medical regulators within Canada and internationally, and an external consultation soliciting feedback on the College's current policy.

- Building upon this research, the Working Group developed an updated draft of the policy which was considered by Council in December, 2016. At this point, Council approved the draft policy for external consultation.

CURRENT STATUS:

- Council is provided with a report on the consultation, as well as a summary of the revisions 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 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 a brief online survey, or by posting comments to a consultation-specific webpage.

- The consultation was held from December 12th, 2016, until February 10th, 2017.

Number of responses

- In total, 104 submissions were received in response to this consultation. This included 54 comments either submitted by mail or posted to the online discussion page, and 50 online surveys.

- Approximately 77% of respondents identified themselves as physicians, 13% as members of the public, 6% as "other" or "unidentified", and 4% as organizations[1].

Feedback

- All stakeholder feedback has been posted publicly on the consultation-specific page of the College's website.[2]

i. General comments

- Broadly speaking, consultation respondents expressed appreciation for the opportunity to comment on the draft policy.

- When asked about the clarity of the draft, respondents to the online survey agreed that it was clearly written (74.42%), easy to understand (76.74%), well organized (76.74%), and articulated clear expectations for physician conduct (72.09%).[3]

- With respect to the comprehensiveness of the draft, 70% of survey respondents agreed that it addressed all of the relevant issues related to ending the physician-patient relationship.

- Respondents were most divided with respect to whether the expectations articulated in the draft policy were reasonable. While only 43.95% of survey respondents agreed that the draft policy articulated reasonable expectations for physicians (41.02% disagreed, and 15.03% did not know), the majority of issue-specific feedback focused on the reasonableness of the policy with respect to two issues: unpaid fees and rostered practices.

ii. Key issue-specific feedback

- While the consultation feedback covered a wide range of issues, including specific suggestions to improve the clarity, flow, and technical accuracy of the draft, the following is a summary of the key issue-specific feedback received:

"The draft policy reflects a bias in favour of patients' interests"

- A number of physician respondents expressed the view that the draft policy was biased in favour of patients' interests, particularly because it did not reference the role that patients play in maintaining an effective relationship. These respondents

[1] Organizational respondents included: The Professional Association of Residents of Ontario (PARO), the Ontario Medical Association (OMA), the Ontario Medical Association Section on General and Family Practice, and the Information and Privacy Commissioner of Ontario (IPC).
[2] A complete summary of the online survey feedback is not yet available. It will be posted alongside the written feedback as soon as the survey report has been finalized.
[3] The reported percentages include both respondents who "strongly" and "somewhat" agreed with the relevant survey question.

further suggested that the "patient-centric" tone of the draft policy may discourage physicians from ending the physician-patient relationship, even where doing so was appropriate, or in cases where patients were behaving in a manner that was threatening or abusive.

Where patients have failed or refused to pay an outstanding fee

- While the consultation draft of the policy acknowledged that physicians were entitled to receive and pursue payment for the uninsured services rendered to a patient, or for any other outstanding fees, it prohibited physicians from ending the physician-patient relationship *solely* because the patient failed or refused to pay an outstanding fee.

- In developing this expectation, it was the opinion of the Working Group that unpaid fees, *on their own*, were not sufficient grounds for termination, except where it was part of a broader pattern of problematic conduct. In this way, the draft policy did permit physicians to consider ending the physician-patient relationship in extenuating circumstances, while strongly discouraging physicians from terminating patients due to a single or minor unpaid fee.

- In reviewing the stakeholder feedback, it was apparent that many physician respondents interpreted this section of the draft policy to mean that physicians were never permitted to end the physician-patient relationship in these circumstances. This interpretation was also shared by some organizational respondents, including the Ontario Medical Association (OMA).

- In light of this interpretation of the draft policy, response to this section of the draft policy was predominately negative, as physicians argued that they should not be required to effectively provide "free care" to recalcitrant patients.

Where patients have sought care outside of a rostered practice

- As with unpaid fees, it was the opinion of the Working Group that seeking care outside of a rostered practice, *on its own*, was not appropriate grounds for termination, except where it was part of a broader pattern of problematic conduct. In this way, the draft policy did permit physicians to consider ending the physician-patient relationship in unusual cases, including where patients had repeatedly sought care outside of a rostered practice without appropriate justification, while strongly discouraging physicians from terminating patients due to a single incident.

- A large number of consultation respondents interpreted this section of the draft policy to mean that physicians were never permitted to end the physician-patient relationship with patients who had sought care outside of a rostered practice, even where it occurred repeatedly and without justification.

- Organizational respondents, including the Professional Association of Residents of Ontario (PARO) and the OMA Section on General and Family Practice, suggested that the draft policy should provide more guidance on this issue. They further suggested that physicians be advised to consider de-rostering recalcitrant patients and providing care on a fee-for-service basis as an alternative to termination.

Application of the draft policy to specialist physicians / Actions specialists must undertake when ending the physician-patient relationship

- Based on the consultation feedback, the application of the draft policy to specialist physicians practising outside of primary care was not well understood (this view was expressed by 39.02% of survey respondents). In particular, some physician respondents were unclear as to the actions specialist physicians were expected to undertake when ending the physician-patient relationship, including the arrangement of a "face-to-face" discussion with the patient. Some specialist physicians argued that it was often impractical, unnecessary, and sometimes unsafe to have face-to-face discussions with each patient, and that sending written notification to the referring physician should be considered sufficient to satisfy the notification requirement of the policy.

B. Revisions in Response to Feedback

- All of the consultation feedback has been carefully reviewed and used to develop a revised draft of the policy (Appendix A).

- All proposed revisions have been undertaken with the assistance of the policy Working Group, Dr. Angela Carol, and Jessica Amey.

<u>Key Revisions and Additions</u>

- Overall, the revised draft policy retains the key content and central principles of the consultation draft, while changes have been proposed in response to stakeholder feedback, to ensure technical accuracy, and to enhance clarity and flow.

- A summary of the key proposed revisions are set out below:

1. Update the introduction of the policy to reference the role of patients in maintaining an effective physician-patient relationship *(lines 2 - 6)*

- In light of stakeholder feedback which suggested that the draft policy failed to recognize or acknowledge the important role that patients play in maintaining an effective physician-patient relationship, it is proposed that the final policy include a new and expanded introductory paragraph which references the fact that the physician-patient relationship can be thought of as a "partnership", and that this partnership benefits from the mutual respect of the physician *and* the patient.

2. Update the Purpose & Scope section of the policy to emphasize the application of the policy to specialists practising outside of primary care *(lines 23 – 31)*

- In an effort to be responsive to stakeholder feedback, and to further clarify the application of the policy to specialist physicians, two revisions are proposed:

  1) The Purpose & Scope section more explicitly states that *all* expectations contained in the draft policy apply equally to specialist physicians practicing outside of primary care;
  2) Examples of circumstances that may arise between specialist physicians and patients have been added to further emphasize when the policy applies (i.e. *not* in cases where a patient's treatment has reached its normal or expected conclusion, and/or the patient's care has been transferred back to his/her referring physician).

3. Where patients fail or refuse to pay an outstanding fee *(lines 114 - 125)*

- In light of stakeholder feedback which suggested a lack of support or clear understanding with respect to this issue, it is proposed that this content be reframed and relocated to the section entitled "*Situations which may lead a physician to consider ending the physician-patient relationship"*.

- By moving this content it should now be clearer that a failure to pay outstanding fees, in some cases, *may* be appropriate grounds for ending the physician-patient relationship.

- Broadly speaking, these proposed revisions do not substantively alter the expectations that were articulated in the consultation draft of the policy. Instead, the expectations are reframed and expanded to ensure that it is clear when it *is* and is *not* appropriate to end the physician-patient relationship due to a failure to pay fees.

- Specifically, the revised draft policy is more explicit with respect to the circumstances that may justify termination:

  > *"In circumstances where a patient has refused to pay an outstanding fee, or has accumulated a number of unpaid fees and provided no reasonable justification for nonpayment (such as evidence of financial hardship), physicians may consider ending the physician-patient relationship."*

- Furthermore, the revised draft policy also now requires physicians to consider the financial burden that the fee may place on the patient, and "if appropriate, consider waiving or allowing for flexibility with respect to fees based on compassionate grounds".

4. Where patients have sought care outside of a rostered practice *(lines 127 - 142)*

- As with the content related to unpaid fees, it is proposed that the expectations related to patients who have sought care outside of a rostered practice be relocated to the section entitled "*Situations which may lead a physician to consider ending the physician-patient relationship"*.

- By moving this content it should now be clearer that in some cases, it *may* be appropriate to end the physician-patient relationship with a patient who has sought care outside of a rostered practice, particularly where it has occurred repeatedly, without appropriate justification, and following a clear warning.

- This section has also been significantly expanded to include more substantial guidance with respect to when it may be appropriate to end the physician-patient relationship in these circumstances.

- Furthermore, a footnote has been added *(# 9)* which reminds physicians that patients may be de-rostered from a practice, and care may be provided on a fee-for-service basis as an alternative to termination.

5. Actions to be taken when ending the physician-patient relationship *(lines 162 - 167)*

- To help promote clarity and to further reinforce the Working Group's position, it is proposed that *lines 162 - 163* be revised to emphasize the application of this section to specialist physicians practising outside of primary care (consistent with the updated Purpose & Scope section of the policy).

- Furthermore, and in response to stakeholder feedback, it is proposed that the draft be revised to clarify that it is only *recommended* that physicians meet with their patients in-person to inform them of the decision to end the physician-patient relationship, and that this only be undertaken when it is *possible* and *safe* to do so *(lines 165 - 167)*.

- These proposed revisions do not represent a substantive change, but a clarification of the existing recommendations.

- Following careful consideration, it was the decision of the Working Group to not revise the policy to remove the requirement that specialists notify each patient of the decision to end the physician-patient relationship in writing. It was the opinion of the Working Group that this requirement was not unnecessarily onerous, and that the principles underlying this expectation, including the importance of clear and direct communication, were not dependent on whether care was being provided by a primary care provider or a specialist physician.

NEXT STEPS:

- Should Council approve the draft policy, as revised, it will be published in *Dialogue* and will replace the current version of the policy on the CPSO website.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the revised draft *Ending the Physician-Patient Relationship* policy?

2. Does Council approved the revised draft policy as a policy of the College?

Contact: Cameron Thompson, Ext. 246

Date: May 3, 2017

Appendices:

A. Revised Draft *Ending the Physician-Patient Relationship* policy

The College of Physicians and Surgeons of Ontario

Ending the Physician-Patient Relationship

Introduction

An effective physician-patient relationship is essential for the provision of quality medical care, and it forms the foundation of the practice of medicine. It is also a partnership which benefits from the mutual trust and respect of both the physician and the patient. While this relationship is of central importance to the practice of medicine, circumstances may sometimes arise which lead either the physician or the patient to end the physician-patient relationship.

This policy sets expectations for physicians when ending the physician-patient relationship. These expectations reflect both the fiduciary nature of the physician's role, as well as the inherent vulnerability of patients when faced with the discontinuation of care.

Principles

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

1. Acting in the best interests of their patients;
2. Respecting patient autonomy with respect to lifestyle, healthcare goals, and treatment decisions;
3. Treating patients with respect and without discrimination during all stages of the physician-patient relationship, even if the relationship faces discontinuation;
4. Appropriately balancing the duty that is owed to each individual patient with the duties that are also owed to patients, staff, colleagues, and themselves;
5. Participating in the self-regulation of the medical profession by complying with the expectations set out in this policy.

Purpose & Scope

This policy articulates the College's expectations of physicians when ending the physician-patient relationship. These expectations apply equally to all physicians, regardless of specialty or area of practice.

For specialist physicians, the expectations of this policy apply only when ending the physician-patient relationship prior to reaching the normal or expected conclusion of the patient's treatment or assessment (for example, as the result of a significant conflict with the patient). When, in the normal course of providing care, a specialist's involvement with a patient reaches its natural or expected

The College of Physicians and Surgeons of Ontario

conclusion (for example, because the treatment or assessment have concluded, and/or the patient's care has been transferred back to their referring physician), this policy does not apply.[1]

Furthermore, this policy does not apply in situations where a physician ends the physician-patient relationship due to the physician's retirement, relocation, leave of absence, or as a result of disciplinary action by the College of Physicians and Surgeons of Ontario.[2]

Policy

Physicians must comply with the expectations set out in this policy when ending the physician-patient relationship.

This policy is organized as follows:

- The first section of this policy contains general expectations for physicians who are considering ending the physician-patient relationship;
- The second section sets out specific examples of situations which may cause a physician to consider ending the physician-patient relationship, and clarifies when this may be appropriate or inappropriate; and
- The third section sets out the actions physicians must undertake when ending the physician-patient relationship.

1. Expectations for physicians who are considering ending the physician-patient relationship

When considering whether to end the physician-patient relationship, physicians must apply good clinical judgment and compassion in each case to determine the most appropriate course of action. In every case, physicians must bear in mind that ending the physician-patient relationship may have significant consequences for the patient, for example, by limiting their access to care, or by reducing their level of trust in the medical profession.

For this reason, physicians must undertake reasonable efforts to resolve the situation affecting their ability to provide care in the best interest of the patient, and only consider ending the physician-patient relationship where those efforts have been unsuccessful.

In some limited cases, however, a patient may pose a genuine risk of harm to the physician, the physician's staff, or to other patients. In these cases, it may not be possible or safe to attempt to resolve

[1] In some cases, patients may not clearly understand or be aware that their involvement with a specialist has reached its natural or expected conclusion. To help promote clear expectations, it is recommended that specialist physicians proactively discuss with each patient what he/she can expect with respect to the anticipated duration of care, and clearly communicate when the relationship has reached its conclusion.

[2] Expectations for physicians in instances of retirement, relocation, leave of absence, or disciplinary action are included in the CPSO policy Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close their Practice Due to Relocation.

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the conflict with the patient directly, and physicians are under no obligation to engage with the patient prior to ending the physician-patient relationship.

2. Situations which may lead a physician to consider ending the physician-patient relationship

While all physicians are expected to act first and foremost in the best interests of their patients, there may be times when physicians' ethical and professional obligation to provide care to an individual patient is in conflict with their other important duties or obligations, such as those owed to their other patients, colleagues, or themselves. In circumstances such as these, physicians may consider ending the physician-patient relationship.

The following examples include situations in which it may be appropriate to end the physician-patient relationship; however, each case is ultimately fact-specific. Physicians must always use their own professional judgment, in keeping with this policy, to determine whether discontinuing the relationship is appropriate.

(i) There has been a significant breakdown in the physician-patient relationship

An effective physician-patient relationship is essential for the provision of quality medical care. This relationship is built upon mutual trust and respect between the physician and the patient. Where these qualities are absent or have been undermined, the provision of quality care may be compromised.

Examples of situations that may lead to a significant breakdown in the physician-patient relationship include, among others:

- Prescription-related fraud;
- Where the patient frequently misses appointments without appropriate cause or notice;
- As a result of behaviour which significantly disrupts the practice;
- Other forms of inappropriate behaviour, including abusive or threatening language;
- Where the patient poses a risk of harm to the physician, staff, colleagues, and/or other patients.

Except where there is a genuine risk of harm, physicians must only end the physician-patient relationship after reasonable efforts have been made to resolve the situation in the best interest of the patient. These efforts must include:

- Proactively communicating expectations for patient conduct to all patients;[3]
- Considering whether a particular incident or behaviour is an isolated example, or part of a larger pattern; and
- Having a discussion with the patient regarding the reasons affecting the physician's ability to continue providing care.

[3] For example, physicians can fulfil this expectation by establishing office policies and posting them in a prominent location.

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(ii) The physician wishes to decrease his/her practice size

Over the course of a physician's career, there may be factors that impact the number of patients a physician is able to effectively manage. These factors may include, as examples: the stage of the physician's career, the status of the physician's health or well-being, or the physician's career goals. In these circumstances, it may be necessary for the physician to decrease the number of patients to whom care is provided.

As each practice and patient population is unique, physicians must exercise their own professional judgment, consistent with this policy, in selecting which patients to remove from their practice.

Whatever method a physician uses, it must be fair, transparent, and compassionate, and take into account the medical needs of each patient. Physicians must also consider any other relevant factors, including the patient's vulnerability, and the patient's ability to find alternative care in an appropriate timeframe.

In reducing a practice size, physicians must not selectively or disproportionately discharge difficult or complex patients.

(iii) The patient has been absent from the practice for an extended period of time

When a patient has not been in contact with a practice for an extended period of time (for example, several years), some physicians may assume that the patient has sought care elsewhere, and seek to remove the patient from the practice.

Before formally ending the physician-patient relationship, physicians must make a good-faith effort to determine whether the patient would prefer to maintain the relationship. This effort must include, at minimum, a letter of inquiry sent to the patient's last known address.

Where no response is received, or the patient indicates that care has been sought elsewhere, physicians may formally remove the patient from the practice.

(iv) The patient has refused to pay an outstanding fee

In the course of providing care, physicians may sometimes charge patients for services that are not covered by the Ontario Health Insurance Plan (OHIP). These uninsured services may include sick notes for work, copies of medical records, and some uninsured medical procedures[4].[5] Physicians are entitled to pursue and receive payment for these services.

In circumstances where a patient has refused to pay an outstanding fee, or has accumulated a number of unpaid fees and provided no reasonable justification for nonpayment (such as evidence of financial hardship), physicians may consider ending the physician-patient relationship. In these cases, the

[4] For example, uninsured medical procedures may include elective cosmetic procedures.
[5] For more information about charging fees for uninsured services, see the College's *Block Fees and Uninsured Services* policy.

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discontinuation of the relationship must be undertaken in accordance with the general expectations of this policy, including that reasonable efforts be undertaken to resolve the situation in the best interest of the patient prior to discontinuing care. In making this decision, physicians must consider the financial burden that paying the fee will place on the patient, and if appropriate, consider waiving or allowing for flexibility with respect to fees based on compassionate grounds. [6,7]

(v) The patient has sought care outside of a rostered practice

Rostered practices[8] impose specific commitments on both family physicians and their patients: physicians commit to provide comprehensive and timely care, and patients commit to seek treatment only from their enrolling physician or group except in specified circumstances. When patients seek care outside of a rostered practice, except in these specific circumstances, there is a risk that the physician's trust and the patient's continuity of care may be undermined.

Where a patient has sought care outside of a rostered practice without appropriate justification, physicians are advised to consider the factors that may have led the patient to seek care outside of the practice (including the physician's own availability), discuss their expectations with the patient, and remind the patient of his/her commitment to the practice.

Physicians must only consider ending the physician-patient relationship in these circumstances if the patient has been given clear information about their obligations within the rostered practice, the patient has received an appropriate warning, and the patient has continued to wilfully seek care outside of the practice without appropriate justification. In these cases, the discontinuation of the physician-patient relationship must be undertaken in accordance with the general expectations of this policy, including that reasonable efforts be undertaken to resolve the situation in the best interest of the patient prior to discontinuing care[9].

Physicians must not end the physician-patient relationship in the following circumstances

(vi) Where it is prohibited by legislation

Physicians must ensure that any decision to end the physician-patient relationship is compliant with relevant legislation. This legislation includes:

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[6] 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."

[7] For further expectations related to fees for uninsured services please see the College's policies on Block Fees and Uninsured Services, Medical Records, and Third Party Reports. Physicians are further reminded that, in accordance with the College's Third Party Reports policy, they are encouraged to refrain from requiring prepayment for uninsured services on compassionate grounds, when the patient or examinee is responsible for payment directly, and the report relates to basic income and health benefits.

[8] Patient rostering in family practice is a process by which patients register with a family practice, family physician, or team. Patient rostering facilitates accountability by defining the population for which the primary care organization or provider is responsible, and facilitates an ongoing relationship between the patient and provider.

[9] Such efforts could include derostering the patient and providing care on a fee for service basis.

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- *The Commitment to the Future of Medicare Act, 2004*, which prohibits physicians from ending the physician-patient relationship because the patient chooses not to pay a block or annual fee[10];
- The Ontario *Human Rights Code*, which prohibits ending the physician-patient relationship due to one of the protected grounds set out in the Code;[11,12]
- The professional misconduct regulations[13] under the *Medicine Act, 1991.*

(vii) Solely because the patient chooses not to follow the physician's advice

Physicians must respect patient autonomy with respect to lifestyle, healthcare goals, and treatment decisions[14], and not end the physician-patient relationship solely because a patient chooses not to follow their advice, or seeks treatment to which the physician objects on the basis of conscience or religious beliefs[15].

For example, it would be inappropriate for a physician to discontinue the physician-patient relationship solely because the patient did not follow the physician's advice with respect to smoking cessation, drug or alcohol use, or the patient's decision to refrain from being vaccinated or vaccinating his/her children.

3. Actions to be taken when ending the physician-patient relationship

When physicians decide to end the physician-patient relationship, regardless of their speciality or area of practice, the College expects them to undertake the following actions:

1. Notify the patient of the decision to discontinue the physician-patient relationship.

   The College recommends that, whenever it is possible and safe to do so, physicians notify each patient of their decision to end the physician-patient relationship in person, to help ensure clear communication.

   In all cases, physicians must provide every patient with written notification that the relationship has been discontinued (See Appendix A for a sample letter). Whichever method physicians use to transmit the written notification, it must be secure and ensure patient

[10] CPSO expectations related to block fees are outlined in the College's Block Fees and Uninsured Services policy.
[11] Protected grounds include: age; ancestry, colour, race; citizenship; ethnic origin; place of origin; creed; disability; family status; marital status (including single status); gender identity, gender expression; receipt of public assistance (in housing only); record of offences (in employment only); sex (including pregnancy and breastfeeding); and sexual orientation.
[12] For more information about physician's obligations under the Ontario *Human Rights Code,* please see the College's Professional Obligations and Human Rights policy.
[13] Ontario Regulation 856/93, as amended (made under the Medicine Act, 1991), s. 1(1)7.
[14] *Health Care Consent Act*, *1996.*
[15] The College's expectations for physicians who limit care due to conscience or religious beliefs can be found in the Professional Obligations and Human Rights policy.

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confidentiality (acceptable methods of transmission include, among others: hand delivery to the patient during an appointment, registered mail, and courier).[16]

In most cases, it is appropriate and useful for the patient to be advised of the reasons why the relationship is being discontinued; however, physicians may use their discretion in situations where there is a genuine risk of harm associated with communicating those reasons to the patient.

2. Document in the patient's medical record the reasons for the discontinuation of the physician-patient relationship, and all steps undertaken to resolve the issues prior to discontinuation.

3. Clearly convey to the patient that he/she should seek ongoing care.

4. Be as helpful as possible to the patient in finding a new physician or other primary care provider, and provide him/her with a reasonable amount of time for doing so, unless the patient poses a genuine risk of harm. In determining what a 'reasonable amount of time' is for a particular patient, physicians are advised to take into account the following:

    - What is considered 'a reasonable amount of time' depends on the circumstances of each case, including the patient's specific healthcare needs.
    - This period can usually be defined as the amount of time it would take a person using reasonable effort to find a new physician; however, physicians must also seek to accommodate patients with special needs or disabilities that may make seeking new care challenging.
    - 'A reasonable amount of time' may vary from community to community, depending on the availability of alternative healthcare providers.
    - Sometimes it may be impossible for a patient to find a new physician. In such circumstances, the College would not expect the physician to continue to provide care indefinitely, but would expect that he/she would provide care in an emergency, where it is necessary to prevent imminent harm.

5. Ensure the provision of necessary medical services in the interim.[17] This may include:

    - Renewing prescriptions, where medically appropriate, for a reasonable length of time given the needs of the patient, the time required to find a new physician, and the nature of the medication;[18] and
    - Ensuring appropriate follow-up on all laboratory and test results ordered.[19]

[16] A copy of the written notification and confirmation of receipt must be retained in the patient's medical record.
[17] Discontinuing professional services that are needed may constitute professional misconduct unless alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services (O. Reg. 856/93 s.1(1)7).
[18] It is not expected that prescriptions will be renewed indefinitely. All prescribing should be done in accordance with the College's Prescribing Drugs policy.
[19] For further information on appropriate follow-up, refer to the CPSO policy on Test Results Management.

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6. Inform the patient that he/she is entitled to a copy of his/her medical records, and provide an estimate of any fees associated with providing copies of, and/or transferring, medical records.[20]

7. Ensure the timely transfer of a copy or summary of the patient's medical records upon the patient's request.[21]

8. Notify appropriate staff (e.g., office receptionist) that care is no longer being provided to the patient.[22]

9. Notify the patient's other health care providers that care is no longer being provided to the patient if such notification is necessary for the purposes of the patient's care, and if the patient has not expressly restricted the physician from providing information to other health care providers.[23]

[20] In accordance with the College's Medical Records policy, physicians are able to charge a reasonable fee for copying and transferring medical records.

[21] For further information, refer to the CPSO's Medical Records policy.

[22] Such notification should only be provided when the patient has not withheld or withdrawn consent to the collection, use or disclosure of their personal health information by the member of the physician's staff to whom the notification would otherwise be provided.

[23] Under the *Personal Health Information Protection Act*, *2004*, a health care provider may provide personal health information about a patient to another health care provider for the purposes of providing health care or assisting in the provision of health care to the patient. Despite this provision, the Act also gives patients the right to expressly restrict his/her physician from providing another health care provider with his/her personal health information, including whether the physician is providing the patient with services. In cases where a physician is asked by another health care provider for information about a patient that is reasonably necessary for the provision of health care or assisting in the provision of health care to the patient, the physician must notify the other health care provider if they have been restricted from disclosing information about the patient and they may wish to advise the other health care provider to direct any inquiry to the patient him/herself for a response.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: General by-law amendments – Compensation Committee

FOR DECISION

ISSUE:

Council is being asked to amend the General By-law to eliminate the Compensation Committee as a standing committee of Council.

BACKGROUND:

Until 2012 the Registrar's annual performance review and adjustments for compensation were conducted by the President. In 2012, Council instructed the President to formalize these processes and in October, Council approved recommended by-law changes which:

(a) delegated the function of reviewing the performance of the Registrar and setting the compensation of the Registrar to the Executive Committee

(b) established the composition of a Compensation Committee as a standing committee of the College

(c) set out the composition and duties of the Compensation Committee, which duties included assisting and advising the Executive Committee regarding the Registrar's performance reviews and remuneration.

Under the By-laws, the Compensation Committee reports to the Executive Committee and consists of:

(a) the vice-president

(b) the president

(c) the past president

(d) the current chair of the finance committee; and/or

(e) a public member of the Executive Committee

This structure was established as a means to operationalize the Executive Committee's duties relating to the Registrar's performance reviews and compensation.

The Compensation Committee established due diligence processes which included:

- Regular semi-annual and annual performance reviews based on established goals and objectives
- Use of external compensation consultants to ensure remuneration was appropriate and competitive to market
- Use of external legal counsel to review the Registrar's employment agreement
- Review of the Registrar's annual salary adjustments by the College's external auditors

ANALYSIS:

While the Compensation Committee has been effective, we no longer think it is necessary to have a separate committee (which is actually only a subset of the Executive Committee) to act in an advisory capacity to the Executive Committee. The Compensation Committee consists of all members of the Executive Committee with the exception of two members of the Executive Committee. It would be preferable to have the full membership of the Executive Committee involved in conducting the Registrar's performance review and analyzing the Registrar's compensation. Expanding the membership of the Compensation Committee to include all Executive Committee members would make the reporting structure meaningless and possibly confusing. Since Council has already delegated these functions to the Executive Committee, it is recommended that the Executive Committee conduct these functions going forward.

Internal and external legal counsel has also advised that the Executive Committee has the authority to conduct these functions itself without the need for a separate Compensation Committee. Having a notionally separate Compensation Committee with the same membership as the Executive Committee and which reports to the Executive Committee would be confusing and unnecessary.

Proposed procedures are attached to this Briefing Note to assist the Executive Committee to operationalize the processes for these functions. The procedures reflect the due diligence processes that were already established for the Compensation Committee.

Accordingly, Council is being asked to consider eliminating the Compensation Committee as a Standing Committee of Council. The proposed by-law amendments to effect this change are attached in the schedule to this Briefing Note. The proposed by-law amendments include a consequential change to address who signs the Registrar's employment agreement.

Decision for Council:

1. Does Council approve the proposed amendments to the General By-law to eliminate the Compensation Committee?

2. Does Council approve the proposed procedures to operationalize the functions of the Executive Committee regarding Registrar performance review and compensation setting?

Contact: Keven Reay, extension 305
Marcia Cooper, extension 546

Date: May 3, 2017

Appendices:
A) By-law amendments
B) Procedures for the Administration of the Registrar/CEO's Employment, Compensation and Performance Reviews

Appendix A

General By-law Changes

A. Subsection 39(4) of the General By-Law is revoked and the following is substituted:

Executive Committee

39. (4) In order to fulfill its duties under subsection (3)[1], the executive committee shall,

(a) consult with Council in respect of the performance of the registrar and with respect to setting performance objectives in accordance with a process approved from time to time by Council;

~~(b) receive the advice of the compensation committee, and~~

(b) ensure that ~~decisions with respect to~~ the appointment and re-appointment of the registrar are approved by Council; and

(c) approve a written agreement setting out the terms of employment of the registrar.

B. Section 41 of the General By-Law is amended by revoking "8 Compensation Committee".

Establishment

1. The following committees are the standing committees.

1 Council Award Selection Committee
2 Education Committee
3 Finance Committee
3a Governance Committee
4 Methadone Committee
5 Nominating Committee *[repealed: May 2003]*
6 Outreach Committee
7 Premises Inspection Committee
~~8 Compensation Committee~~

[1] 39 (3) In addition to the duties of the executive committee set out in section 30 of this by-law and section 12 (1) of the Health Professions Procedural Code under the *Regulated Health Professions Act*, the executive committee shall review the performance of the registrar and shall set the compensation of the registrar.

C. Section 47.3 of the General By-Law is revoked.

~~**Compensation Committee**~~

~~**47.3** (1) The compensation committee shall be composed of:~~

~~(a) the vice-president~~

~~(b) the president~~

~~(c) the past president~~

~~(d) the current chair of the finance committee; and~~

~~(e) a public member of the Executive Committee~~

~~(2) The compensation committee shall report to the executive committee and shall assist the executive committee in reviewing the performance of the registrar and in setting the compensation of the registrar.~~

~~(3) In performing its duties, the compensation committee shall follow a process approved from time to time by Council.~~

D. Section 4 of the General By-Law is amended by adding the following as subsection 4(8):

Expenses

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

Appendix B

May 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Executive Committee

Procedure for the Administration of the Registrar/CEO's

Employment, Compensation and Performance Reviews

Purpose

Under the General by-law, the Executive Committee is delegated the authority by Council to review the performance of the Registrar/CEO and set the compensation and terms of employment of the Registrar/CEO.

Reporting

The Executive Committee will report to Council.

Duties and Responsibilities

- With the assistance of external legal counsel, negotiate the Registrar/CEO's employment agreement, revisions and renewals.
- Using an external compensation consultant, establish appropriate and competitive remuneration and compensation administration practices for the Registrar/CEO.
- In collaboration with the Registrar/CEO, establish annual performance objectives and measurements for the Registrar/CEO.
- Formally evaluate the performance of the Registrar/CEO, a minimum of twice annually, based on established performance objectives and measurements or any other criteria as identified by the Executive Committee.
- Approve annual compensation adjustments for the Registrar/CEO based on established College compensation administration practices or in accordance with the Registrar/CEO's employment agreement.
- Ensure that the Registrar's annual compensation adjustment have been reviewed by the external auditor.
- Maintain confidentiality of discussions and negotiations.

Support

The Committee will be supported by the Head of Human Resources.

Annual Performance Assessment and Compensation Administration Processes

Timing is subject to change in order to align with Council meetings and/or strategic or operational planning.

Actions	Timing
Annual assessment: The President will advise Council of the upcoming annual performance review and will solicit Council member feedback. • Feedback will be collected in writing or through personal interviews. • Council members will identify themselves in the feedback but when the information is shared with the Registrar/CEO identifying information will be removed.	September Council
The Executive Committee (with support from H.R.) will collect any other information relevant to performance, which may include 360 feedback, strategic results, Registrar/CEO's mid-term results , self-assessment and Committee members' personal observations.	Fall
The Registrar/CEO will meet with the Executive Committee, present results for the past year and recommend performance objectives for the next fiscal year. The Committee will ensure that objectives are aligned to strategy and the proposed budget.	Fall
The Executive Committee will approve an annual compensation adjustment for the Registrar/CEO based on performance in accordance with established College compensation administration practices or as set out in the Registrar/CEO's employment agreement.	Nov/Dec
The President will meet with the Registrar/CEO to give performance results and confirm objectives for upcoming year. The President will document performance for the HR file and will advise Human Resources of Registrar/CEO's salary adjustment.	Nov/Dec
Results of the Registrar/CEO's performance review will be presented as information to Council *in camera*.	December Council
Mid-term performance assessment: The Registrar/CEO will report to the Executive Committee on performance to date against objectives. The Committee will provide feedback and revise performance objectives if necessary.	June
At any time, if performance concerns are identified by the President or Executive Committee, they must be reported to Council at the earliest opportunity.	

Terms of Employment Renewal/Extension Process

1. Prior to the end of the Registrar/CEO's employment agreement, the Executive Committee will discuss the desirability to renew or extend the employment agreement with the Registrar/CEO (any existing employment agreement may stipulate deadlines for when either a new agreement must be finalized or formal notice to end the agreement must be given).

2. The Executive Committee will advise Council of the agreement status and the desire of the Registrar/CEO to re-new or extend the agreement.

3. If renewal/extension is to be considered, the Executive Committee will conduct a multi stakeholder performance review (internal and external).

4. The President will present Executive Committee's recommendations to Council regarding terms of employment renewal or extension. A report to Council should include:
    - Overview of performance throughout the terms of the prior employment agreement
    - Results of multi-stakeholder feedback
    - Any other relevant non-financial details about performance or goals for the next term of employment

5. If Council approves renewal or extension of the Registrar/CEO's employment, the Executive Committee will have the authority to proceed and finalize a new employment agreement.

6. The terms of employment will be negotiated by the Executive Committee.

7. The Registrar/CEO's employment agreement, and any revisions or renewals thereof, will be signed by one of the President or Vice-President.

8. The President will advise Council when a new employment agreement has been finalized and signed.

Recruitment Process

1. If either party declines to seek renewal or extension of the terms of employment, the Executive Committee will conduct a search. Human Resources will engage an executive search firm, after an appropriate RFQ process.

2. Role of the Executive Committee in the search process:
    - Select an executive search firm, with the support of Human Resources.

- Recommend to Council a search process and identify any other individuals who should be part of the search process.
- Conduct interviews.
- Present a final candidate to Council for approval.
- Negotiate the terms of employment and employment agreement.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

PRESENTATION

The North American Opioid Crisis – An Overview

Guest Speaker: Dr. David Juurlink, Medical Toxicologist

The Hospital for Sick Children

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: OPIOIDS
Methadone Committee Transition
Opioid Strategy Framework

DATE: May 2017

For Decision

ISSUE:

Canada is in the midst of an opioid crisis, with the second highest rate of opioid prescribing/use per capita in the world and escalating overdose deaths in multiple provinces.

The CPSO has a role to play in managing physician clinical and professional performance to fulfill its public protection mandate.

This briefing note considers the current context, outlines the CPSO role and roles of others, sets out planned changes to the methadone committee and proposes a strategy framework to respond to the opioid crisis. Council is asked to approve the planned changes to the methadone committee and strategy framework.

Background

Avoiding Abuse, Achieving a Balance: Tackling the Opioid Crisis

In 2009, the CPSO initiated a public policy project to address escalating concerns in Ontario communities related to opioid prescribing, dispensing and misuse.

A comprehensive public report *Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis* was released in 2010. It contained 31 recommendations (Appendix A) aimed at ensuring the effective treatment of patients with chronic non-cancer pain while stemming the illicit diversion of opioids into the community.

Key recommendations included:

- Creating a coordinated, accessible system for the treatment of pain and addiction;
- Taking immediate steps forward to make greater use of technology to improve outcomes for patients and reduce diversion;
- Enhancing the training and ongoing education of health-care providers and improving education and awareness of the public;

- Empowering health-care professionals, institutions and law enforcement agencies to reduce diversion by facilitating information-sharing and establishing a duty to report criminal activity.

Most of the recommendations in the report were not solely within the College's jurisdiction; they also required commitment from government, collaboration between stakeholders, and funding. Although few of the recommendations were implemented at the time, almost all have been repeated or reflected in the Minister of Health's current opioid strategy, released in late 2016.

In 2014, the College considered including Opioids as one of 4 strategic initiatives included in the Strategic Plan. Ultimately, the issue was considered to be non-strategic, but work continued on various issues that have arisen since that time.

The biggest change for the CPSO since 2010 has been the receipt of prescribing data from the Narcotics Monitoring System (NMS) at the Ministry of Health, which has occurred periodically since 2013. With this data, the CPSO has the capability to provide oversight of some physician prescribing in Ontario.

Other Jurisdictions

Other jurisdictions in Canada and the US have also been struggling with significant opioid issues and have responded in a variety of ways. Generally speaking, regulatory bodies have focused their actions in 3 areas:

- Education - requiring some form of opioid prescribing education,
- Guidelines - endorsing or requiring compliance with clinical guidelines, and
- Policy - setting out specific expectations of physicians relating to prescribing ie. accessing medication profiles or limiting doses.

This is in addition to any work regulators do as part of a Prescription Monitoring Program, where this is in place.

Both the College of Physicians and Surgeons of BC (CPSBC) and College of Physicians and Surgeons of Alberta (CPSA) have released new standards relating to opioid prescribing.

CPSBC

The CPSBC endorsed the CDC's clinical guidelines in 2016 and revised their *Safe Prescribing of Drugs with Potential for Misuse/Diversion* standard in 2016 CPSBC Guidelines. It says that physicians must review current medications, prescribe the lowest effective dosage, and offer naloxone to appropriate patients. It also says that physicians must not prescribe benzodiazepines to patients on Long Term Opioid Therapy (LTOT) or prescribe methadone or fentanyl without training.

CPSA

The CPSA has taken a number of steps in response to the opioid crisis:

- Writing to every physician who has prescribed an opioid, and sending specific communications to physicians who have prescribed over 90 OME/day
- Releasing a new CPSA Prescribing Standard indicating that physicians must check a patient's medication history prior to prescribing, be able to justify any prescribing decisions, discuss prescribing decisions prior to prescribing, and meet a number of additional requirements when prescribing.
- Communicating with the public about its activities Message to patients.

In March, the Executive Committee heard a presentation from Dr. Beth Sproule, Clinician Scientist, CAMH about Prescription Monitoring Programs (PMPs) across Canada. These programs vary across the country, where they exist. Dr. Sproule focused on the most developed programs, in Nova Scotia, BC, Alberta, Saskatchewan and Manitoba. Her key observations were:

- PMPs are one strategy to reduce prescription drug abuse
- Evidence for the effectiveness of PMPs is inconsistent (because of variation in features, clinician use, outcome measures and other interventions), but promising
- There is not always one program for comprehensive planning, evaluation and reporting.

CPSO Role and Objectives

Opioids issues are complex. The current crisis – increased use of opioids, as well as increased dependence, addiction and overdose – has many contributing factors. Physician prescribing is one of those factors, and a significant one, but it is not the only reason that many communities are struggling with opioid use in their communities. Socioeconomic factors, availability of illicit drugs, increased strength of illicit drugs, and a lack of services to support chronic pain, mental health and addiction have all contributed to the current situation.

The introduction of oxycontin by Purdue in 1995 and its subsequent aggressive marketing to and acceptance by physicians is widely seen as a significant contributor to the current crisis. As the current crisis has taken 20 years to develop, it will take some time to address some of these problems, and multiple strategies will be required. Reliance on isolated responses (tamper proof oxyneo, delisting of particular formulations, etc.) and the belief in single factor solutions has led to both anticipated and unanticipated problems.

Because of these complexities, and the multiple organizations involved, the CPSO needs to establish and clarify its role in addressing this crisis; in particular, what is the CPSO responsible for, what can it advocate for and what it should leave entirely to others. The CPSO also needs to be clear about its goals, in light of its public protection mandate and commitment to focus on issues that put the public at risk.

The overall objectives of the College's opioid initiative are to:

> Facilitate safe and appropriate opioid prescribing by physicians to patients,
>
> Protect patient access to care, and
>
> Reduce risk to both patients and the public.

More specific objectives could also include the following; however, not all these things are within the College's jurisdiction, particularly since we do not have direct access to the data that would identify patterns:

- Reduced initiations on Long Term Opioid Therapy (LTOT)
- Maintenance or tapering of patients on high doses
- Prevention of rapid opioid escalation
- Maintaining access for patients to prescribers of opioids
- Compliance with guidelines
- Decreased overdoses/decreased deaths due to overdoses.

Appropriate opioid prescribing is supported when the elements set out below are in place. Areas where the CPSO has primary responsibility are shaded.

	Element	Primary Accountability	CPSO Accountability
1	Real time access to patient medication profiles for physicians (and pharmacists)	**Ministry of Health** The MOH is responsible for the medication profile and the systems that support it and provide access. This information is expected to be available to physicians by the end of 2017.	CPSO successfully advocated for expedited inclusion of NMS data in the drug profile viewer. Once medication profiles are available to physicians, the CPSO needs to decide whether physicians will be expected to access this information prior to prescribing opioids. This can be addressed via the Prescribing Drugs Policy review.
2	Reporting of meaningful comparative opioid prescribing data to physicians for practice improvement	**Health Quality Ontario** HQO has been tasked with including opioid prescribing indicators in the existing Primary Care Practice reports.	The CPSO is liaising with HQO re development of indicators. Once these are complete, the CPSO will facilitate the distribution of reports to physicians where possible, promote their use and potentially integrate the reports into current assessment processes.

	Element	Primary Accountability	CPSO Accountability
3	Guidelines	**Michael DeGroote National Pain Center – McMaster** McMaster is responsible for the national clinical guidelines, which were released on May 8, 2017.	The College's statement in response to the guidelines is included here. The CPSO will update its Prescribing Drugs policy to reference the revised clinical guidelines.
4	Policy	**CPSO** The Prescribing Drugs policy sets out the requirements for prescribing. The section on narcotics that refers to the previous guidelines will be updated. The College could set out other expectations for prescribing opioids, such as checking the medication profile prior to prescribing or receiving and reviewing the Primary Care Report from HQO when it is available. The 50-90 OME/day recommendation could also be included as an expectation in the policy.	
5	Prescriber compliance[1] with guidelines	**CPSO** The CPSO's role is to ensure that physicians practice safely. Since the guidelines inform the standard of practice, the CPSO will need to ensure that physicians are practising to the standard. Absolute compliance with clinical guidelines is neither achievable nor desirable, given the need to address specific patient situations. However, physicians should be aware of the guidelines and be able to explain any diversion from them.	

[1] Compliance needs to be defined, but it would include following all the elements of the guidelines (assessment, evaluation of pain, trying other strategies, management of addiction, etc., not just the amount of opioid).

	Element	Primary Accountability	CPSO Accountability
6	Analysis of prescribing data to enable the identification of low, moderate and high risk prescribing	**Ministry of Health** The MOH has prescribing data, in addition to billing and patient data that provides important clinical context for prescribing. However, aside from statistics about opioid rates across the province, the MOH has not yet used analytics to identify low risk prescribers, possible fraudulent activity by patients or providers, or potential risk scenarios (high levels of initiation or escalation).	The CPSO has developed the algorithms currently used to identify high risk prescribing. There will be a MOH-CPSO group to identify further algorithms that will include other stakeholders.
7	**Investigative** responses to support improved prescribing commensurate with the level of risk identified.	**CPSO** For high risk matters, CPSO is using its investigative authority to obtain further information and take action as required. Investigations may identify risk of harm to patients of continued prescribing in some circumstances. However, there is also a risk of harm to patients of discontinuing prescribing. Many patients are on doses of opioids that exceed both the current watchful dose (200 OME/day) and the proposed doses in the revised guideline (50-90 OME/day). In order to balance these risks, the goal of investigations is to support continued prescribing under supervision where remediation is possible.	
8	**Assessment**	**CPSO** The CPSO is responsible for the assessment of physicians to ensure competence. The CPSO currently conducts methadone assessments, but it does not conduct specific opioids assessments. There is the potential to manage defined cohorts of physicians via a broader set of interventions including a QA assessment. See further information below about proposed changes to the mandate of the Methadone committee.	

	Element	Primary Accountability	CPSO Accountability
9	**Education** responses to support improved prescribing commensurate with the level of risk identified.	**Others** The primary responsibility for educating the profession at large is not entirely clear. There is a role for Undergraduate, Post Graduate and CPD education for both prevention and in response to identified problems.	The CPSO's current role has been related to remediation - finding educational resources to improve prescribing for physicians with an identified prescribing issue. The CPSO does not offer a prescribing course, but supports the UofT prescribing skills course via funding and course content.

Methadone Committee

As noted above, the College has an important role in the oversight of methadone prescribing, which is part of the opioids discussion.

Background:

- In 1996, the College assumed oversight of a program for prescribing methadone for the treatment of addiction. The program was set up under contract to the Ministry of Health and Long Term Care (MOHLTC). In 1999, the Methadone Committee was formed to oversee assessments of methadone prescribers.

- Since 2010, the College has been considering changes to the governance and role of the Methadone Committee, intended to broaden the committee's focus beyond methadone, for the following reasons:
    - The introduction of the opioid agonist alternative buprenorphine and its increasing use as the first line treatment for opioid dependence
    - 2016 recommendations from the MOHLTC Methadone Treatment Services and Advisory Committee[2] which identify clear roles for the College relating to both methadone *and* opioids more broadly.

- As a result of these considerations, changes were made to move away from a specific focus on methadone. These included dissolution of the patient registry, closure of the telephone support line and transition of the annual prescriber's conference.

- In 2015, the Executive Committee directed staff to begin exploring with the Methadone Committee mechanisms to address issues around opioids more generally.

[2] http://health.gov.on.ca/en/public/programs/drugs/ons/docs/methadone_advisory_committee_report.pdf

- Additional reasons for considering opioids more generally at that time included:
    - Concerns arising from the increase in use of fentanyl and resulting overdose deaths;
    - Lack of oversight of physicians prescribing methadone for pain management, and;
    - Increasing prescriptions of Buprenorphine by family physicians (which do not require an exemption).

Proposed Governance changes

- The Executive Committee is proposing that the Methadone Committee transition to a specialty panel of the Quality Assurance Committee (QAC).

- This specialty panel would assume responsibility for the assessment activities currently managed under the Methadone Committee.

- The benefit of transitioning the Methadone Committee to the QAC is to ensure that the full range of powers under the RHPA can be utilized when the Committee determines education and remediation for a prescriber are required. These powers include conducting more comprehensive assessments, directing SCERPs and, when necessary, using the authority of Section 80.2 of the Code to impose terms, limits and conditions or refer matters to the ICRC.

- The Methadone Committee is a committee created by College by-law and its status can be rescinded by Council.

Implementation

- The QAC, under its current authority, can start to direct assessments of methadone prescribers before any changes are made to the by-law.

- The transition of the Methadone Committee to a specialty panel of the QAC will be a staged process. In the initial stage the committee will retain the current membership, use the existing assessment tool and MMT Standards and Guidelines, and continue with the same frequency of assessments (1, 3, 5 years).

- The current members of the Methadone Committee will be formally appointed to the QAC with required orientation and training. Methadone assessors and prescribers will also be provided support in the transition to the new model.

- Panels with particular expertise in addictions or pain management will be convened depending on the issue to be considered.

- Existing QAC committee policies will be revised to address issues of selection for and frequency of assessment for methadone prescribers.

- When the operational processes for the specialty panel have been established, the by-law will be rescinded. Rescinding the Methadone bylaw does not require circulation to the membership under the *Health Professions Procedures Code*.

- In future, consideration will be given to the following:
    - expanding the specialty panel's mandate to assessing physicians who prescribe opioids (in addition to the opioid agonist methadone),
    - the required frequency of assessment,
    - how physicians identified through the Narcotic Monitoring System could be assessed and, where necessary, remediated, without the need for an investigation,
    - composition of the panel, and
    - triggers for assessment.

Methadone Exemptions

- Physicians currently require an exemption from Health Canada to prescribe methadone for addiction. The College has never been involved in the exemption process for methadone for pain.

- Currently Health Canada does not approve methadone exemptions for addiction without information from the College – a methadone prescriber assessment, completion of the core Opioid Dependence course at the Centre for Addiction and Mental Health (CAMH) and a two day preceptorship with an approved prescriber.

- However, in 2016, the Federal Minister of Health indicated an intention to re-examine the exemption requirements for prescribing methadone and signalled a possible move away from a focus on methadone. There is concern that the exemption requirements may discourage physicians who would be prepared to prescribe methadone, compromising patient access to the drug.

- In light of this, the College is exploring the possibility of ceasing to provide information to Health Canada in support of a physician's application for an exemption to prescribe methadone for addiction, as long as access to methadone in Ontario is not compromised.

Next Steps:

- A communications strategy will be developed to ensure prescribers and the public are reassured the College continues to take the prescribing of methadone very seriously and the transition under the QAC ensures additional powers for education and remediation through the RHPA.

- In 2016, the College presented its final Methadone conference. CAMH will continue to offer an annual education event for prescribers of methadone.

- CAMH has also agreed to discuss assuming responsibility for the Methadone Maintenance Treatment Standards and Guidelines document developed by the CPSO which are currently due to be revised.

Decision for Council

1. Does Council direct staff to proceed with the transition of the Methadone Committee from a by-law Committee to a specialty panel of the Quality Assurance Committee (QAC)?

Proposed Opioid Strategy Framework

This strategy is focused on the CPSO's key regulatory responsibilities as outlined above. Its goals are to:

- clearly articulate the CPSO's role in opioid issues;
- bring all drug and prescribing-related issues at the CPSO under one comprehensive, cohesive umbrella; and
- ensure there is a consistent and principled approach to opioids both within the College and when interacting with external stakeholders.

1 Guide

- Expedite review of Prescribing Drugs policy to include updated guidelines and new expectations, as required.
- Facilitate review of MMT guidelines.

2 Assess

- Continue focused methadone assessments via the methadone program.
- Expand focus of assessments to opioid prescribing via QAC.
- Identify and assess moderate risk opioid prescribing, avoiding need for investigations.

3 Investigate

- Identify, investigate and monitor high risk (problem) opioid prescribing.

4 Facilitate Education

- Work with partners to
  - ensure multiple educational offerings, widely available and targeted at multiple levels and multiple stages of practice: general education, awareness, and remediation.
  - develop an Opioid Prescribers Education Series, focused on the fundamentals of appropriate prescribing and particular areas of focus to be determined. The CPSO would work with others to develop multiple sessions over 2017/2018.

Opioid Strategy Principles

The Opioid Strategy will be informed and enabled by several key principles, which will include the following:

1 Communicate

- Provide updates on CPSO actions relating to opioids in the key areas.
- Continue Dialogue coverage in every issue until the end of 2018. Include articles from multiple perspectives, including patients and families.
- Compile all Dialogue articles into a resource package for distribution or foundation for other educational initiatives.
- Communicate directly with patients and the public.
- Develop an Opioids Statement that clearly sets out the role of the College, physicians and system partners. This could be an interim to the revisions to the policy.

2 Use Data and Analytics

- Accessing, analyzing and acting on prescribing data are key enablers of the strategy framework. The CPSO cannot fulfill its regulatory responsibilities to assess and investigate without access to information about physician prescribing. Physicians cannot prescribe appropriately without access to medication profiles and information about their own prescribing patterns.
- Ultimately, the College want to be able to identify the factors that are associated with inappropriate prescribing in order to prevent inappropriate initiations, dose escalation and addiction.

3 Collaborate

- For the activities that are not the CPSO's primary responsibility, the CPSO will collaborate with key stakeholders – Health Quality Ontario, the MOH, eHealth Ontario, and others – to promote safe prescribing and access to information for physicians.

Federal Opioids Action Plan

The activities included in the Opioids Strategy Framework incorporate the public commitments made by the CPSO in the Federal Opioids Action Plan. These include:

- **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.

Considerations

- There is a significant Government Relations component to the opioids work, given the ownership of the database by the Ministry of Health. Responsibility for opioids issues rests with multiple areas of the MOHLTC – Drug Programs, Strategy, Data Analytics – and activities are not always coordinated.

- Media coverage of opioids issues has been fairly constant since early 2016, and is likely to continue.

  - The *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* was released on May 8, 2017. A link to the guideline is here. Most of the content of the guideline, including its recommendation to limit doses to between 50 and 90 OME/day, was anticipated. However, it will have implications for physicians as they work to incorporate the guideline recommendations into their practices.

- Prioritization and sustained focus on the opioids issue will require resources, both externally and internally. Considerable resources have been focused on the current investigations: investigators, legal and assessors. Once this work is completed, resources will be required for the monitoring function. Transitioning the Methadone Committee to QAC will be a significant project, as will any move to manage NMS referrals at the QA level.

NEXT STEPS:

- Given the importance of this issue, and the fact that there are already multiple internal and external groups working on opioid issues, the Executive Committee has proposed that it maintain oversight of the Opioids Strategy Framework and other activities, similar to the model used for managing the issues relating to the Sexual Abuse Initiative.

- The focus of work over the next 6 months will include:

    1. Development and coordination of the Opioid Prescribers Education Series
    2. Communications, with potential development of an Opioids Statement
    3. Oversight of the methadone transition to QAC
    4. Revisions to the Prescribing Drugs Policy
    5. Delivering on commitments made in the Federal Opioids Action Plan

Decision for Council

Does Council approve the proposed Opioid Strategy Framework?

DECISIONS FOR COUNCIL:

Does Council direct staff to proceed with the transition of the Methadone Committee from a by-law Committee to a specialty panel of the Quality Assurance Committee (QAC)?

1. Does Council approve the proposed Opioid Strategy Framework?

Contact: Maureen Boon, Ext 276
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Date: May 8, 2017

Appendix A: Recommendations: *Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis*

Appendix A: Recommendations: *Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis*

1: Academic institutions should improve education for health-care professionals in training to develop core competencies in pharmacology, pain management and opioid addiction, and enhance inter-professional training of health professionals.

2: The Government of Ontario and academic institutions should fund the expansion of continuing education programs about chronic pain and opioid use, and undertake a comprehensive needs assessment for health professionals in practice to fill any educational gaps in these areas.

3: The *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* should be considered the authoritative reference for the development of educational programs for healthcare providers.

4: Health-care educators and regulators should collaborate on developing competencies/performance indicators based on the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* for use in relevant quality assurance activities, as well as appropriate resources to assist clinicians with self-evaluation.

5: The Government of Ontario should spearhead a campaign involving key stakeholders to address public education priorities regarding the safe use of opioids.

6: The Government of Ontario should incorporate evidence-based information about opioid use and misuse in the school curriculum.

7: The Government of Ontario should provide support for youth opioid education awareness initiatives.

8: The Government of Ontario and the Office of the Chief Coroner should develop an educational program for the Judiciary and Crown Attorneys on opioids – the appropriate use of opioids, the dangers of opioids as prescription drugs, and the impact on Ontario communities.

9: The Governments of Ontario and Canada should work in collaboration with First Nations communities and other relevant agencies and groups to examine opioid use and abuse among First Nations and develop relevant educational programs for these communities.

10: The Government of Ontario should make it a priority to address the spectrum of opioid issues in Ontario on a system-wide basis.

11: Treatment of chronic non-cancer pain and addiction should follow an inter-professional approach.

12: The Government of Ontario should oversee the development of a comprehensive pain management strategy in the Local Health Integration Networks (LHINs) to support effective treatment of chronic non-cancer pain and addiction; facilitate the creation of an integrated network of specialized pain clinics across the province; and work with the CPSO to develop an effective regulatory framework for specialized pain clinics.

13: Physicians should prescribe non-opioid medication for pain management where clinically indicated.

14: The Government of Ontario should work with and through the LHINs to ensure patient access to comprehensive treatment of opioid addiction throughout the province.

15: Primary care physicians should be encouraged to prescribe buprenorphine for opioid-addicted patients where clinically indicated.

16: The Government of Ontario should fund all healthcare providers that are involved in the management of chronic non-cancer pain and addiction. The government should work with the Ontario Medical Association on amending the OHIP fee schedule relevant to pain management to ensure fair remuneration for physicians practising in this area.

17: The Government of Ontario should move immediately to make all opioid prescription information for all people available to all prescribers and dispensers by June 2011.

18: The Government of Ontario should pass enabling legislation to allow for a Drug Information System (DIS) by 2012 that would:

• Compile all drug information for all patients in a single repository;
• Provide secure electronic access to real-time information regarding all drugs for all individuals to all prescribers and dispensers; and
• Include a component Drug Monitoring System to improve the prescribing and dispensing of monitored drugs and minimize diversion.

19: The Government of Ontario should make the legislative changes needed to allow for all prescription information for all patients to be collected, used and disclosed to all prescribers and dispensers.

20: All prescribers and dispensers should have appropriate access to real-time information in the Drug Information System and be able to access it through their electronic medical records.

21: Ensure tools from the *Canadian Guideline on Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* to support appropriate drug prescribing are accessible to prescribers.

22: The Government of Ontario should enable ePrescribing across the province by building on the success of the ePrescribing pilot projects currently being run through eHealth Ontario's Medication Management Strategy to improve efficiencies in prescribing and improve clinical outcomes for patients.

23: The Government of Ontario should work with stakeholders to ensure the appropriate sharing of information and protection of privacy.

24: The Government of Ontario and OntarioMD should provide prescribers, dispensers and patients with enhanced access to online educational tools and resources for prescribing, dispensing and use of prescription opioids.

25: Health regulatory colleges should make computer literacy a standard of practice and should educate health-care professionals on the benefits of EMRs and privacy best practices.

26: The Government of Ontario should pass enabling legislation to develop and implement a Drug Monitoring System as a component of the Drug Information System to improve the prescribing and dispensing of monitored drugs and minimize diversion by 2012.

27: The Government of Ontario should amend the *Personal Health Information Protection Act (PHIPA)* and the *Freedom of Information and Protection of Privacy Act (FIPPA)* to require a regulated health professional, the head of an institution and a health information custodian to disclose personal information to a police service without a warrant where he/she has reasonable and probable grounds to believe that a law of Ontario or Canada, including the *Criminal Code* or the *Controlled Drugs and Substances Act*, has been contravened.

28: The Government of Ontario should amend Section 36 (1)(e) of the *Regulated Health Professions Act,1991* to require employees, committee members and Council members of regulatory health colleges who are responsible for the administration of the *Act* to disclose information (including personal health information) to a police service without a warrant if he/she has reasonable and probable grounds to believe that an offence may have been committed contrary to the *Controlled Drugs and Substances Act*, the *Criminal Code*, or the laws of Ontario or Canada.

29: The Government of Ontario should repeal Section 36(1.3) of the *Regulated Health Professions Act, 1991*.

30: Police services in Ontario should be required to disclose to a college of a regulated health profession or group of health professions in all cases where a member is under investigation and the police have reasonable and probable grounds to believe that an offence may have been committed contrary to the *Controlled Drugs and Substances Act,* the *Criminal Code*, or the laws of Ontario or Canada.

31: The Government of Ontario should review the issue of opioid abuse, addiction and diversion and allocate additional resources to train drug enforcement officers, and fund drug enforcement at the municipal and provincial level to enable officers to step up drug prevention, enforcement and investigation.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: Government Relations Report

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 spring session of the Ontario Legislature is scheduled to end on June 1 for its summer break. It has been a busy last session with a heavy legislative agenda.
- The next provincial election is only 13 months away, scheduled for June 7, 2018 and all three political parties are working hard to improve their chances of forming government, or at least holding onto as many seats as possible.
- On April 27, the Wynne government delivered their 2017 budget, the first balanced budget in a decade. This was widely seen as a "good news" budget with a focus on health care as well as new funding for child care spaces, money to build schools, measures aimed at seniors and previously announced cuts to electricity bills and plans to cool the housing market.
- The key announcement of the budget is the creation of a province-wide $465 million a year pharmacare program for all young people in Ontario under the age of 25 that will cover the 4,400 prescription drugs currently listed on the Ontario Drug Benefit. This program that the government is calling OHIP+, will take effect on January 1, 2018 and will be accessible to all Ontarians regardless of income and coverage will be automatic with no upfront costs.
- The NDP came out with their own phrmacare plan just days before the Liberal's announced theirs, which proposes a $475 million a year universal coverage plan for all Ontarians, covering a smaller pool of medications. The PCs have indicated that their position on pharmcare, as well as on hydro pricing, will be

set out in their election platform.

- The Wynne government has been consistently lagging behind the PCs and NDP in the polls, although any impact of the Liberal's recent activity and budget remains to be seen.
- The PCs remain ahead in the polls yet leader Patrick Brown is still largely unknown to Ontarians.
- The costs of hydro and affordability issues in general have continued to be a central focus of opposition parties at Queen's Park. Over the course of this session though, attention has somewhat shifted to executive compensation levels, following the release of the 2016 Sunshine List, the skyrocketing costs of housing in the GTA, and plans for an Ontario pharmacare program.
- Hospital and health care funding – including the ongoing unrest with Ontario's doctors following three years of working without a contract, as well as potential school closures have also continued to be a focus in this session.
- On May 3, a writ was issued for a by-election in Sault Ste. Marie, to be held on June 1. David Orazietti resigned in December after holding the riding since 2003. Debbie Amaroso is the former mayor and is running for the Liberals; Ross Romano is running for the PCs and is a City Councillor; Joe Krmpotich is the NDP candidate and is also a City Councillor.
- All three parties will be working hard to win the by-election in hopes that it will be an indication of electoral success in next year's general election.

2. Legislative Issues of Interest

Bill 84, the Medical Assistance in Dying Statute Law Amendment Act, 2017

- At the time of writing this note, Bill 84 is expected to soon pass third reading and receive Royal Assent.
- The bill was introduced on December 7, passed second reading on March 9, and was referred to Committee for hearings and further consideration.
- The Committee held hearings on March 23 and March 30. Dr. Rouselle presented to the Committee on March 30 and the College made a written submission that can be read by clicking here.
- Bill 84 aligns with the federal MAID legislation and provides greater clarity and protections on issues related to MAID that fall under provincial jurisdiction. Bill 84 includes the following amendments to existing Acts:
    - Changes to the Coroner's Act so that the Coroner continues to be given notice of all MAID deaths but the investigation of these deaths would be left to the Coroner's discretion;
    - Immunity for physicians, nurse practitioners and anyone assisting them, from actions or proceedings arising from the lawful provision of MAID;

  - Clarifying 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; and
  - Changes to privacy legislation to ensure that identifying information about clinicians and facilities that provide MAID cannot be disclosed pursuant to a Freedom of Information (FOI) request.
- Although Bill 84 did not include any provisions relating to effective referral or the conscience rights of providers, these issues became a focus in 2nd reading debate and at Committee.
- The lobbying efforts on the part of conscientious objectors were significant. Many individual "objecting" physicians, as well as Cardinal Thomas Collins, religious groups, and the OMA all spoke against the College's requirement for an effective referral.
- Although smaller in number, the Committee did hear from physicians who have provided MAID and are in support of our policy. Organizations like the Registered Nurses Association of Ontario (RNAO), Dying With Dignity Canada, the Ontario College of Pharmacists, and the College of Nurses of Ontario also spoke favourably about health provider's obligations to provide an effective referral.
- During the clause by clause consideration of Bill 84—the time whereby the opposition parties and government can suggest amendments to proposed legislation—the PCs put forward amendments to protect the conscience rights of providers. The amendments did not pass.
- On May 3, PC health critic Jeff Yurek introduced a private member's bill, *Bill 129, Freedom of Conscience in Health Care, 2017* that brings forward the same provisions the party introduced in clause by clause. Bill 129 is scheduled for 2nd reading debate on May 18. The College is reviewing the Bill.
- The government's commitment to establish a Care Coordination Service (CCS) that will assist patients and caregivers in accessing additional information and services for MAID, as well as other end-of-life issues was added to the Bill during clause by clause. That section reads:

  Care co-ordination service
  13.10 The Minister shall establish a care co-ordination service to assist patients and caregivers in accessing additional information and services for medical assistance in dying and other end-of-life options.
- The Minister has said that this CCS will be up and running by late May 2017.

Bill 87, the Protecting Patients Act, 2017

- 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*.
- Some of the more significant provisions in the Bill include the following:
  - 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;
    - Specifying how Colleges are to perform its functions dealing with complaints, reports, discipline and incapacity matters when it relates to misconduct of a sexual nature;
    - 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;
    - Amending the Code so that a discipline panel is prevented from ordering gender-based restrictions in any case (not just sexual abuse);
    - Changes to Colleges' Patient Relations Committee (PRC) in regards to eligibility criteria and new Ministerial regulation making authority setting out additional functions of the PRC; and
    - Increased transparency measures focused on the Colleges' public registers.
- The Bill was introduced on December 8 and completed 2nd reading on April 3, in unusually fast timing, after only one week of debate.
- This Bill is significant for the College with implications for all areas of the institution including every statutory committee, College bylaws and more.
- Council considered the Bill in February and the College's submissions followed the direction provided.
- On April 26, the College President presented to the Standing Committee considering Bill 87 and made a comprehensive written submission that can be read by clicking here.
- The College's submission clearly articulates our overall support for the government's objectives to strengthen the sexual abuse and transparency provisions in the RHPA, and, to improve the complaints, investigation and discipline processes. That said, the submission advocates for important and substantive amendments to Bill 87 and contains precise drafting language. The most significant concerns outlined in the submission are as follows:

    Sweeping new Ministerial regulation-making authority

    - The most significant concern with Bill 87 is the sweeping new undefined regulation-making authority with respect to the structure of the College's s seven statutory committees.
    - This authority is extremely broad and will place important governance matters that are currently addressed in the statute, in regulations outside of the legislative process.
    - Our submission suggests an alternate and focused approach that enhances the integrity and accountability of College discipline processes through ensuring complete separation between the Discipline Committee and the Council, with no overlap in membership

between the two entities. This would enhance the integrity and perception of independence of the discipline process and would involve a broader pool of public representatives in the work of the Discipline Committee.

Definition of Patient

- The Bill proposes a definition of patient for the purpose of sexual abuse allegations.
- Although the College supports the intended objective – to prohibit sexual relationships between physicians and former patients we have significant concerns with how the Bill sets out to do this.
- First, the draft provision specifies that a patient is an 'individual who was a member's patient within the last year' but doesn't state or define the incident to which the one-year period would be anchored.
- Second, the draft provision only applies to sexual abuse matters. Matters before the Discipline Committee can contain blended allegations --sexual and non-sexual. The existence of the physician-patient relationship would be relevant to both and yet patient would be defined differently in the context of each allegation. This would increase the complexity of hearings and create risk of legal error by discipline panels.
- Our submission makes specific suggestions for remedying these problems.

Protecting and supporting patients

- The College submission suggests a number of amendments to help ensure the Bill meets its intended objectives of better protecting and supporting patients in relation to sexual abuse.
- While we express support for the new powers of the ICRC to restrict or suspend prior to a referral to the Discipline or to the Fitness to Practise Committees, we believe that important drafting changes are necessary to enhance the clarity of the language and ensure Colleges have the necessary tools to achieve the intended objective of patient protection.
- The Bill does not address the use of private patient medical records (third party records) during sexual abuse hearings. This is a significant issue that must be addressed to respect patient rights and, to avoid creating a 'chill-effect' amongst survivors with respect to their willingness to come forward to the College when they have been sexually abused by physicians. We propose amendments to raise the threshold as to when these patient records would have to be produced.

Mental Health Act & Discipline Processes

- The submission also suggests an important amendment to clarify that section 35(9) of the *Mental Health Act* is not applicable to College hearings.
- This amendment is necessary to ensure the College can access records necessary to assess the competence of physicians practising in psychiatric facilities without being subject to unnecessary and onerous processes that could be harmful to patients.

Supporting Public Council Members

- We also recommend a number of essential changes related to public member related issues including workload and compensation.
- Our submission suggests, as we have done numerous times over the years, that Colleges be given the authority to compensate public members for their work.

Other matters

- The College's submission also touches on the need for information sharing with police about non-members; important technical changes required in the sections related to transparency; and advocates for enhancing supports to patients and victims of sexual abuse through the Patient Relations Committee.

- The President and College staff have ensured decision-makers are aware of the College's suggested amendments to the Bill and our rationale for making these suggestions.
- At the time this note was written, hearings on the Bill were still underway with clause-by-clause deliberation scheduled for May 17 and May 3, although this timing is subject to change. The College has advocated for more time between the last day of hearings on May 10 and clause by clause in order to allow adequate time to develop amendments to the Bill to ensure that the substantive amendments that have been put forward (particularly those designed to strengthen the sexual abuse provisions) can be properly considered and incorporated as the Bill moves through the legislative process.
- The College will continue to actively participate in the legislative process as the Bill moves forward.

3. Government Relations Activities

- The College's government relations activities have been focused on Bills 87 and 84. Work on Bill 87 will likely continue to dominate our attention over the coming months.
- The College continues to work closely with government on a number of other

files including government's management of the public appointment process, the regulation of fertility services, facility oversight, and issues surrounding opioids and medication management.

- Over the last month, the President has met with a number of MPPs from all three parties to discuss the College role and Bills 84 and 87.
- We anticipate a busy end to the final weeks of the spring session and a full and active government relations agenda for the College for the remainder of 2017 and into 2018.

Contact: Louise Verity, Ext. 466
Miriam Barna, Ext, 557

Date: May 5, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Mifegymiso – Abortion Combination Pill
2. Medical Assistance in Dying - MOHLTC Proposed Care Coordination Service
3. Policy Consultation Update:
    I. Uninsured Services: Billing and Block Fees
4. Policy Status Table

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1. Mifegymiso – Abortion Combination Pill

- Mifegymiso is now available in Canada for the termination of pregnancy up to 49 gestational days. When this drug was approved by Health Canada, the information available lacked clarity on the process of dispensing and administering Mifegymiso.

- At the direction of the Executive Committee in January, staff developed messaging to the membership explaining the dispensing and administering processes for Mifegymiso. This was done in collaboration with the Ontario College of Pharmacists to ensure alignment with the messaging that was being developed for their membership.

- The College and the OCP have now finalized messaging to their respective memberships. The messaging outlines the 3 options available for dispensing Mifegymiso:

    1. Physicians can sell and dispense the medication to the patient in accordance with CPSO's Dispensing Drugs policy, or

2. Patients can take the prescription to a pharmacy of their choice and have the medication delivered to the physician's office, or
3. Patients can take the prescription to a pharmacy of their choice and receive the medication directly from the pharmacist.

- Included in the message is clarification that ingestion of the medication does not need to be in front of the physician. Instead, the physician and the patient can discuss options and determine what is best for each patient.

- The messaging indicates that a mandatory training program has been developed for all physicians and pharmacists involved in the prescribing and dispensing of Mifegymiso.

- This messaging was posted to the CPSO website on March 7, 2017 and has been distributed through Dialogue. It has also been posted to the College's social media outlets.

2. Medical Assistance in Dying - MOHLTC Proposed Care Coordination Service

- In December 2016, the Minister of Health announced that the provincial government would establish a Care Coordination Service (CCS).

- The purpose of the CCS would be to assist patients and caregivers in accessing additional information and services for medical assistance in dying (MAID), as well as other end-of-life options.

- The CCS would both replace and expand the services currently offered through the province's Clinician Referral Service.

- The CCS would capture the following requests:

    - Self-directed requests from patients and family members/caregivers who are seeking more information about MAID and/or wish to be connected to a clinician that will assess them for MAID.

    - Requests from clinicians who are unwilling to assess a patient's eligibility for MAID and/or provide MAID and must connect the patient with a willing provider to fulfill the College's effective referral requirement.

    - Requests from clinicians who have already completed an assessment of a patient for MAID, but are looking for a second assessor (as required by federal law) and/or a clinician who will perform the procedure (i.e., administer or prescribe the drugs).

- Requests from clinicians seeking a connection with a willing community pharmacists or pharmacies.

- In order to respond to the above-listed requests, the CCS would maintain a central list of willing clinicians, including physicians, nurse practitioners, and community pharmacists/pharmacies.

- The CCS does not replace or alter the College's requirement that objecting physicians provide patients with an 'effective referral'.

- Given that a referral to an agency is one way of meeting the effective referral requirement, the CCS could be considered an agency for that purpose. As stated in the *Medical Assistance in Dying* policy, physicians or their designate are expected to make a timely referral, in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency.

Next Steps

- The Minister of Health has most recently committed to launching the CCS in May 2017.

- The College will continue to monitor all aspects of MAID closely, including work on the CCS, and will keep Council apprised of developments.

3. Policy Consultation Update

I. Uninsured Services: Billing and Block Fees

- The Block Fees and Uninsured Services policy is currently under review. The policy sets out expectation for physicians who charge for uninsured services and/or offer patients the option of paying for uninsured services by way of a block fee.

- Council considered an updated and newly titled *Uninsured Services: Billing and Block Fees* draft policy at its February meeting and approved it for external consultation.

- As of the Council submission date (May 5, 2017), the College received a total of 117 responses to this consultation (70% physicians, 13% members of the public, 2% other health care professions, 5% organizations,[1] and 10% prefer not to say).

[1] The organizational respondents were: Canadian Doctors for Medicare, Credit Valley Family Health Team, FAIR Association, Ontario Medical Association Section on Sport & Exercise Medicine, Ontario Medical Association Section on Respiratory Disease. The Ontario Medical Association also indicated that they would be providing a response at a later date.

These include 52 comments on the College's online discussion page and 65 online surveys.[2]

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website shortly.

- Stakeholders provided feedback covering a range of issues pertaining to uninsured services. A few of the key themes that have emerged throughout the consultation are described below.

i. General Comments

- Broadly speaking, the feedback was polarized. Many respondents, including some physicians, felt that the policy should take a firmer stance on the reasonableness of fees and how block fees are being offered or portrayed to patients. In contrast, many physicians felt the draft policy would inappropriately compel them to work for free and that the College should not be interfering with the fees they charge.

- Notwithstanding the above, a strong majority of survey respondents felt that the policy was clearly written and easy to understand and agreed with the new draft policy expectations pertaining to physicians' role in educating patients about uninsured services, missed appointments, and how block fees are offered.

ii. Specific Comments and Suggestions for Improvement

- **Patient's ability to pay:** Some worried that the requirement to consider the patient's ability to pay when determining what is a reasonable fee, would require patients to identify themselves as being in need (which may cause reluctance or embarrassment) and would require physicians to engage in an assessment of need, for which they have no training.

- **Block fees:** Respondents worried that physicians continue to misrepresent block fees to their patients and that no matter what the College says, some patients will feel compelled to pay the fee for fear of retribution. Respondents also noted that patients may have a difficult time assessing whether a block fee is in their best interest and recommended that the draft policy include additional supports for patients with low literacy or for whom English is their second language.

- **Uninsured alternatives:** It was suggested that the draft policy could more comprehensively address issues that arise when insured and uninsured services are being provided together or when an uninsured service is being proposed as

[2] 69 respondents started the survey, but of these, 4 did not complete any substantive questions – leaving 65 for analysis.

an alternative to an insured service (most notably, cataract surgery). In particular, recognizing that patients in these situations are often vulnerable and that the power imbalance in the physician-patient relationship may compound this vulnerability.

- **Distinction between insured and uninsured services:** Some respondents noted that the policy may require a more nuanced and updated analysis of the insured versus uninsured services distinction. In particular, they felt that the 'basket of services' that are negotiated as part of, for example, Family Health Organization contracts may include some services which have historically been uninsured services or that the nature of these practice models and their remuneration mechanisms are such that physicians ought not charge for these services.

Next Steps

- All feedback received will be carefully reviewed and used to evaluate and revise the draft policy. The revised draft 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 A**. 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/DISCUSSION FOR COUNCIL:

For information only

Contact: Andréa Foti, Ext. 387

Date: May 5, 2017

Appendices:

A. Policy Status Table

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Anabolic Steroids, Substances and Methods Prohibited in Sport	The current policy articulates the College's expectations of physicians regarding the use of anabolic steroids and other substances and methods for the purpose of performance enhancement in sport (i.e., doping).	This review will commence following the May, 2017 meeting of Council. A preliminary consultation is expected to be undertaken after the September, 2017 meeting of Council. Further updates with respect to the status of this review will be provided at a future meeting.	2019
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. A draft of the policy will be presented for consideration to consult externally at the September meeting of Council.	2018
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	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	2018

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	physicians in demonstrating their competence in the new area of practice.	new draft policy is currently being prepared. A draft of the policy will be presented for consideration to consult externally at the September meeting of Council.	
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 (OHIP).	This policy is currently under review. A newly titled Uninsured Services: Billing and Block Fees draft policy was approved for external consultation by Council in February 2017. Further information about the consultation can be found in the Policy Report contained in Council's May 2017 meeting materials. 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
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 has been reviewed in light of the feedback received, and	2017

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		a final draft of the policy will be presented at the May meeting of Council for consideration for final approval.	
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 has been reviewed in light of the feedback received, and a final draft of the policy will be presented at the May meeting of Council for consideration for final approval.	2017
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	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

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.		
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.	2018
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. 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.	2018
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	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	2018

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	effectively in all of their work environments, and 2. Follow-up appropriately on test results.	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.	
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 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.	2018
Confidentiality of Personal Health Information	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation is scheduled to commence after the May meeting of Council. Further updates with respect to the status of this review will be provided at a future meeting.	2018

POLICY STATUS REPORT – MAY 2017 COUNCIL

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.
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.
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,

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
		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 Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social 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	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.

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Companies)		
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 for the End of Life)	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at 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.

POLICY STATUS REPORT – MAY 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
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.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: Fertility Services: Finalized Companion Document "Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises"

DATE: May 25-26, 2017

For Information

ISSUE:

- The CPSO Expert Panel on Fertility Services has finalized the companion document "Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises" that sets out how the OHPIP Standards would be applied to Fertility Services Premises in Ontario.

- This document was developed in response to a request by the Ministry of Health for the CPSO to develop and implement a quality and inspections framework for the delivery of fertility services across the province.

- The Premises Inspection Committee approved the document ('Appendix A') at its March 24, 2017 meeting. The document is being provided to Council for information only.

BACKGROUND:

- In March 2016, an Expert Panel on Fertility Services was convened by the CPSO to assist with the work of developing an effective quality oversight framework for the delivery of fertility premises. The Expert Panel is comprised of physician leaders in reproductive medicine and other health care professionals such as embryologists.

- The Expert Panel developed a draft companion document "Applying the Out-of- Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises" to help fertility services practitioners plan for and participate in their inspection-assessments.

- The document was posted on the College website for external consultation between November 2016 and January 2017.

- The Premises Inspection Committee (PIC), which has responsibility for the implementation of this document as it relates to the Out-of-Hospital Premises Inspection Program (OHPIP), was provided with the consultation feedback at its January 2017 Policy meeting, at which time, PIC also provided feedback on the draft document.

- On February 17, 2017, the Expert Panel considered all stakeholder feedback, including PIC's comments, and finalized the document.

- In March 2017, PIC approved the companion document, with a few minor changes.

Amendments to Regulation

- In February 2017, Council approved the proposed changes to Ontario Regulation 114/94, Part XI (Inspection of premises where certain procedures are performed) made under the Medicine Act, 1991, which will ultimately provide the College with the authority to enter and inspect the premises where fertility services are performed, regardless of whether anaesthesia or sedation is used.

- As of March 2017 the draft regulation was posted on the Regulatory Registry website for the minimum 45-day consultation period. Following the Ministry consultation, the regulation will be formally submitted to government as a regulation amendment proposal.

CURRENT STATUS:

- As the Premises Inspection Committee approved the companion document at its March 24th meeting, staff has begun the development of inspection tools with input from the CPSO Expert Panel on Fertility Services.

NEXT STEPS:

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

- Following Government approval of the proposed regulation change, the CPSO will post the companion document "Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises" to the CPSO website, communicate with stakeholders and begin notifying premises impacted by the amended regulation.

- Fertility services premises inspections will be conducted on a cost recovery basis (similar to the existing OHPIP). Once assessment tools are developed and composition of the assessment teams are finalized, the CPSO will be in a better position to determine actual costs.

- The MOHLTC will establish a quality assurance and inspection committee which will look at quality outcomes from these facilities, which will include a review of outcomes from the CPSO assessments along with data submitted to Better Outcomes Registry and Network (BORN).

DECISION FOR COUNCIL:

For information only

Contact: Shandelle Johnson, extension 401
Kavita Sharma, extension 375
Wade Hillier, extension 636
Dr. Gillian Oliver

Date: April 28, 2017

Appendices: Appendix A: “Applying the Out-of-Hospital Premises Inspection Program in Fertility Services Premises”

Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises

March 2017

College of Physicians and Surgeons of Ontario

Mandate

The profession, through and with the College, has a duty to serve and protect the public interest by regulating the practice of the profession and governing in accordance with the *Regulated Health Professions Act*.

Our Vision – Quality Professionals, Healthy System, Public Trust

Our vision guides our thinking and actions. It defines who we are, what we stand for, the role we see for ourselves, our critical relationships, in what system we work, and the outcomes we seek.

> **Quality Professionals** - as a profession and as professionals, we recognize and acknowledge our role and responsibility in attaining at a personal, professional, and at a system-level, the best possible patient outcomes.
>
> **Healthy System** - the trust of the public and our effectiveness as professionals is influenced by the system within which we operate. We demonstrate leadership by active involvement in the design and function of an effective system, one which is accessible, integrated, informed by evidence and sustainable.
>
> **Public Trust** – we earn trust of the public by ensuring quality professionals and safe care, working collaboratively with partners towards a healthy system, acting in the interests of patients and communities and being accountable and transparent.

Our Guiding Principles – Integrity, Accountability, Leadership and Collaboration

To fulfill our vision of **Quality Professionals, Healthy System, Public Trust** we are guided by the following principles:

> **Integrity** in fulfillment of our mandate and pursuit of our vision, achieved by aligning our goals, behaviours and outcomes and adhering to a high ethical standard.
>
> **Accountability to the public and profession** achieved through an attitude of service, accepting responsibility, transparency of process and dedication to improvement.
>
> **Leadership** demonstrated by proactive regulation of our profession, management of risk and service to the public.
>
> **Collaboration** with health system partners to ensure shared commitment, focus and resources for the common good of the profession and public.

Guiding Policies

It is expected that physicians will manage medical and surgical conditions within the scope of their certification and experience. For all CPSO members this means practicing with the appropriate qualifications or equivalency subject to requirements set out by the RCPSC, or CPSO "Recognition of Non-Family Medicine Specialists" and "Changing Scope of Practice" policies.

Contact Information

Published and distributed by the College of Physicians and Surgeons of Ontario. For more information about the Out-of-Hospital Premises Inspection Program, contact:

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First Edition, March 2017: Members of the CPSO Expert Panel on Fertility Services -

Dr. Gillian Oliver, Chair	Kitchener
Dr. Andrew Browning	Barrie
Mr. Michael Cruz	Markham
Dr. Marjorie Dixon	Toronto
Dr. Ellen Greenblatt	Toronto
Dr. Mathias (Matt) Gysler	Mississauga
Dr. Keith Jarvi	Toronto
Ms. Moya Johnson	Ottawa
Dr. Arthur Leader	Ottawa
Dr. Clifford Librach	Toronto
Dr. Nathan Roth	Toronto
Ms. Heather Sheridan	Markham

Table of Contents

Background

In 2015, the Ontario Ministry of Health and Long-Term Care requested that the College of Physicians and Surgeons of Ontario develop and implement a quality and inspections framework for the delivery of fertility services in out-of-hospital premises (OHPs) and hospital-based settings across the province.

The College, through its **Out-of-Hospital Premises Inspection Program** (OHPIP) supports continuous quality improvement through developing and maintaining standards for the provision of medical care/procedures in Ontario out-of-hospital premises (OHPs), and inspecting and assessing for safety and quality of care. This is mandated by the amendment to Regulation 114/94 under the *Medicine Act* adding **Part XI, Inspection of Premises where Certain Procedures are Performed,** which was enacted on April 9, 2010.

In November 2009, Council adopted the core Out-of-Hospital Premises Standards that are the basis of inspection-assessments for the variety of procedures performed in OHPs.

It is expected that physicians will manage medical and surgical conditions within the scope of their certification and experience. For members of the College of Physicians and Surgeons of Ontario (CPSO), this means practising with the appropriate qualifications or equivalency subject to requirements set by the Royal College of Physicians and Surgeons of Canada (RCPSC), or CPSO "Specialist Recognition Criteria in Ontario" and "Changing Scope of Practice" policies.

Regulation Amendment for Fertility Services

In order to enable the College to oversee premises where fertility services are provided, an amendment was made to *Ontario Regulation 114/94, Part XI (Inspections of premises where certain procedures are performed)* that grants authority to the CPSO to do the following:

(1) Conduct inspections of premises that perform any act in connection with the following procedures: (i) in vitro fertilization, (ii) artificial insemination and (iii) sperm cryopreservation or oocyte cryopreservation;

    Note that physicians who perform the sole act of counselling or referral for the procedures identified above (e.g. in a family practice setting) will not be subject to the inspection regime.

(2) Conduct inspections of any health care facility governed by or funded under The *Public Hospitals Act* that performs the procedures outlined in item 1 (above), and;

(3) Request information from a premises during the course of an inspection (e.g. Better Outcomes Registry & Network (BORN) Ontario reports or data).

For details, please refer to the Ontario Regulation 114/94, Part XI [INSERT HYPERLINK TO REG WHEN APPROVED].

Purpose of this Document

This document was developed to help fertility services practitioners plan for and participate in their inspection-assessments. It does not replace the core OHPIP Standards; rather, it helps the practitioner understand how the OHPIP Standards will be applied in their fertility services practice.

An important distinction needs to be made with respect to the use of terminology in the OHPIP Standards. Wherever there is a reference to "operating room", this would be considered a "procedure room" for the purpose of fertility services.

This Guide should be considered a required companion document to the core OHPIP Standards for practitioners available at http://www.cpso.on.ca/CPSO/media/documents/CPSO%20Members/OHPIP/OHPIP-standards.pdf

All decisions made by the Premises Inspection Committee will be based on the information within these Standards as well as any additional relevant guidelines, protocols, standards and Acts that are current (i.e. CNO standards, national guidelines). This includes requirements set out by other regulatory bodies and provincial guidelines.

How this Document is Organized

For ease of reference, this document has been organized into two parts to coincide with the types of services offered by fertility services premises:

Part I: In Vitro Fertilization (IVF) Units

Part II: Ovulation Induction/Intracervical Insemination/Intrauterine Insemination (OI/ICI/IUI) Units

Within each Part of the document, specific sections of core OHPIP Standards have been clarified to show how they uniquely apply to fertility services premises. Premises are required to comply with the additional requirements outlined in each section.

Note: This Guide should be considered a required companion document to the core OHPIP Standards for practitioners. Premises must also comply where appropriate with all other requirements listed in the core OHPIP Standards.

PART I: In Vitro Fertilization (IVF) Units

NOTE: *Within each Part of this document, the content is further organized as follows:*

a) Specific sections of the core OHPIP Standards have been clarified to show how they uniquely apply to fertility services premises – as such, the numbered sub-sections mirror the numbering in the core OHPIP Standards.

b) Additional requirements with which premises must comply.

This Guide should be considered a required companion document to the core OHPIP Standards for practitioners. Premises must also comply where appropriate with all other requirements listed in the core OHPIP Standards.

2.2.6 – OHP Policies and Procedures

2.2.6.1.1 Administrative

Guidance to the Standard

d) Overnight stays - does not apply.

2.2.6 OHP Policies and Procedures

1. The Medical Director is responsible for the regular review, update, and implementation of OHP policies and procedures, which must address the following areas:

2.2.6.1.1 Administrative:

a) responsibility for developing and maintaining the policy and procedure manual
b) organizational chart
c) scope and limitations of OHP services provided
d) overnight stays, if applicable.

e) ensuring that records kept for each RHP working in the OHP are current and include qualifications, relevant experience, and relevant hospital privileges as appropriate to the RHP.

f) ensuring all physicians performing OHP procedures at the premises have provided online notification to satisfy the regulation requirements (see section 2.2.1), and documentation verifying approval (emails from College staff) is on file.

2.2.6.1.5 Procedures

Guidance to the Standard

In addition to the procedures listed, the following clarification and additions apply:

h) Medical and Laboratory Directives

g) Handling of human gametes (sperm, eggs, embryos) and reproductive tissues in accordance with current CSA Standards

r) Urgent transfer of cryopreserved human cells and tissues for assisted human reproduction

2.2.6.1.5 Procedures:
a) Adverse events: monitoring, reporting, and reviewing
b) Adverse events: response to an adverse event
c) Combustible and Volatile Materials
d) Delegating controlled acts
e) Equipment: routine maintenance and calibration
f) Infection control, including staff responsibilities in relation to the Occupational Health and Safety Act
g) Medications handling and inventory
h) Medical Directives
i) Patient booking system
j) Detailed and clear patient selection/admission/exclusion criteria for services provided at the OHP
k) Patient consent (written or verbal) based on the scope of the OHP practice
l) Patient Preparation for OHP procedures
m) Response to Latex Allergies
n) Safety precautions regarding electrical, mechanical, fire, and internal disaster.
o) Urgent transfer of patients (see Section 2.2.6.1.3)
p) Waste and garbage disposal

Additional Requirements – Policies and Procedures

The Medical Director shall ensure that there are separate policies and procedures documented for each of the clinic subsections (as applicable):

Policies and Procedures (P&P) Manuals for Clinical Subsections

It is recommended that most current Canadian Fertility & Andrology Society (CFAS) guidelines as they apply to assisted human reproduction be included in P&P manuals, where applicable.

1. Physician staff (Including for OI, IUI and IVF Procedures)
2. Nursing staff– should include the policies and procedures governing safe nursing practice in an IVF clinic
3. Ultrasound Services (If an Independent Health Facilities (IHF) Ultrasound licenced facility is within the premises– then, the manual(s) related to ultrasound licence of an IHF is /are acceptable)
4. Biochemistry Laboratory
5. Andrology Laboratory (Including IUI procedures and diagnostic testing)
6. IVF Laboratory
7. Storage and dispensing of medications
8. Information Technology (IT) (to include, but not limited to, EMR services, Data Protection and Privacy, Equipment Maintenance)
9. Housekeeping
10. Reprocessing
11. Administration
12. Research (basic and/or clinical)
13. Counselling (if located at the premises)
14. Ethics oversight (including ethics committee if applicable)
15. Quality Assurance

4.1 General Physical Standards

Guidance to the Standard

Electrical, Standard 4.1.2.2 is clarified as follows:

Emergency power supply should:

- Provide for safe completion of egg retrieval or other related procedures and the safe recovery of the patient;
- Protect the integrity of gametes and embryos within the premises or until they are transferred to another secure facility;

Layout, Standard 4.1.5.2 g) and h) are replaced by:

g) IVF (gamete) laboratory

h) staff change room (where applicable)

Layout, Standard 4.1.5.2 - The following additional items also apply:

i) diagnostic imaging (where applicable)

j) diagnostic laboratories (phlebotomy, biochemistry, andrology) (where applicable)

4.1 General Physical Standards

		Level 1	Level 2	Level 3
1	**Building Codes**	OHP site complies with all applicable building codes including fire safety requirements.		
2	**Electrical**	1. All electrical devices are certified by CSA or licensed for use in Canada. 2. Emergency power supply can provide for safely completing the procedure and recovering the patient.		
3	**Access**	1. Access for persons with disabilities complies with provincial legislation and municipal bylaws. 2. Doors and corridors can safely accommodate stretchers and wheelchairs.		
4	**Size**	OHP size is adequate for all procedures to be performed.		
5	**Layout**	1. Layout facilitates safe patient care and patient flow. 2. These areas are functionally separate: a) administration and patient-waiting area b) procedure room and/or operating room c) recovery area d) clean utility area e) dirty utility room f) reprocessing room g) endoscope cabinet h) staff change room and staff room.		
6	**Emergency Measures**	Provisions are in place to ensure 1. The safe evacuation of patients and staff in case of an emergency, i.e., stretchers, wheelchairs, or other adequate methods of transport are available, and 2. There is appropriate access to the patient for an ambulance to transfer the patient to a hospital.		

4.2 Procedure Room/Operating Room Physical Standards

Guidance to the Standard

Physical Requirements, Standard 4.2.1.1 is clarified as follows:

> c) immediate access to hand-washing or hand hygiene facilities and proper towel disposal

Physical Requirements, Standard 4.2.1.3 is clarified as follows:

Space allows the physician and assisting staff, to move around the procedure table with access to all sides of the patient, and:

- be connected to the embryology lab through a "pass through" window or door for communication
- have a sink conveniently placed for hand washing if ABHR 70% or higher is unavailable or not used

4.2 Procedure Room/Operating Room Physical Standards

Table 04: Procedure Room/Operating Room Physical Standards

	Level 1	Level 2	Level 3
1 Physical Requirements	1. All OHP levels provide: a) lighting as required for the specific procedure b) floors, walls and ceilings that can be cleaned to meet infection control requirements c) immediate access to hand-washing facilities and proper towel disposal d) openings to the outside effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current or other effective means 2. Space can accommodate equipment and staff required for the procedure. 3. Space allows the physician and assisting staff, when sterile, to move around the OR/procedure table with access to both sides of the patient, without contamination.		

4.3 Recovery-Area Physical Standards

Guidance to the Standard

Size and Layout, Standard 4.3.2.1 is clarified as follows:

1 . The size of the recovery area depends on planned use: it must accommodate the volume of patients expected for a minimum of 90 minutes post procedure time, i.e.,

- 1 hour procedure = 2 patients
- 0.5 hour procedure = 4 patients
- 20 minute procedure = 6 patients

4.3 Recovery-Area Physical Standards

Table 05: Recovery-Area Physical Standards

	Level 1	Level 2	Level 3
1 Physical Requirements	1. A sink for hand washing is accessible.		
2 Size and Layout	Level 1 NA	1. The size of the recovery area depends on planned use: it must accommodate the volume of patients expected for a minimum of two hours operating room time, i.e., • 1 hour procedure = 2 patients • 0.5 hour procedure = 4 patients. 2. The recovery area allows for transfer of patients to/from a stretcher and performance of emergency procedures.	
3 Equipment	Level 1 NA	Monitoring, suction, oxygen, and bag-valve mask devices, intravenous and other medical supplies are immediately available.	

4.4 General Medication Standards

Guidance to the Standard

Standard 4.4.1 - The following addition applies:

j) if dispensed under the authority of a physician, medication(s) used in ovulation induction or controlled ovarian hyperstimulation prior to IUI or IVF and after discharge from the procedure must be stored, dispensed and discarded in keeping with the manufacturer's requirements, good medical practice and accounted for on a daily basis. Once dispensed medication leaves the clinic it may not be returned into the medication inventory of the clinic.

Standard 4.4.2 – does not apply.

4.4 General Medication Standards

1. OHPs should:
   a) maintain a general medication inventory record
   b) periodically inspect all medications for viability
   c) date multidose vials of medication on opening and dispose according to manufacturer's guidelines
   d) label medications in accordance with the Food and Drug Act (FDA) and the Controlled Drugs and Substances Act (CDSA) and its regulations
   e) store medications:
      i) according to the manufacturer's recommendations (e.g., refrigeration if required)
      ii) in a manner suitable for security and restocking
   f) store emergency drugs in a common location. In facilities where procedures are done in multiple procedure rooms, a crash cart is advisable
   g) document administration of medications in the patient record
   h) dispense medications at discharge accompanied by verbal and written instructions that are given to the patient and/or accompanying adult
   i) make available resources to determine appropriate drug dosages and usage.
2. If services are provided to infants and children, the required drugs must be available and appropriate for that population.

Additional Requirements – OHP Physical Standards - Embryology

1 Power Supply and Critical Alarm System

- Alternate Power Supply (e.g. generator, batteries, UPS) must be connected to critical equipment.
- Alarm system for critical equipment must have a backup power supply and a system for notification of equipment failure.

2 Temperature and Air Quality

- Highest level of positive pressure that does not compromise gametes
- Air quality systems should be monitored on a regular basis, and the equipment be maintained to meet manufacturer's standards
- Temperature and humidity regulated by thermostats should be tested and adjusted regularly.
- Oxygen sensors should be present and in proper working order in all areas where liquid nitrogen is being used.
- The ventilation system of the andrology and embryology laboratory should be designed to reduce those volatile organic compounds (VOCs) detrimental to gametes and embryos.

5.6 – Nurse Qualifications

Guidance to the Standard:

Standard 5.6.1 - The following clarification applies:

b) additional training and appropriate experience as required for procedures performed including assisting with IVF procedures, counselling and supporting patients receiving treatments, performing delegated medical acts, caring for patients receiving anaesthetic and/or sedation, patient teaching, recognition and treatment of complications e.g., OHSS, and documentation of all interactions with patients.

Standard 5.6.2 - Does not apply.

5.6 Nurse Qualifications

1. Registered nurses (RNs) and registered practical nurses (RPNs) working within their scope of practice in OHPs must hold:
   a) current registration with the College of Nurses of Ontario
   b) additional training and appropriate experience as required for procedures performed
   c) current BLS certification
   d) must have current ACLS if administering sedation to, monitoring or recovering patients (RNs only).
2. Registered Nurses (RNs) working with a pediatric population (14 years and younger), who are involved in monitoring, administering sedation or recovering patients must maintain a current PALS certification.

Additional Requirements – OHP Staff Qualifications - Laboratory Staff Qualifications

1. LABORATORY DIRECTOR

This position has responsibility for the day-to-day operation, management, organization and supervision of the laboratory staff. In addition to being responsible for the laboratory services, the Laboratory Director may also perform laboratory procedures on a regular basis and be involved in training of new employees.

2. LABORATORY SUPERVISOR

The Laboratory Supervisor assumes a lead role in the Assisted Reproductive Technology (ART) Laboratory and *is the responsible person in the absence of the Laboratory Director*. This role has also previously been referred to as “coordinator” or “lead”.

3. EMBRYOLOGIST

The Embryologist performs complex laboratory procedures in an ART Laboratory, which include:

- Performing technical procedures in the ART Laboratory
- Adhering to the standard operational procedures for the ART Laboratory, and
- Demonstrating competency in obtaining and processing of gametes and embryos

4. ANDROLOGIST

Some larger ART programmes, or specialized IUI/donor sperm programmes, have dedicated ART Andrology Laboratory staff members who do not have embryology responsibilities. A person who provides specialized andrology services in the ART Laboratory is designated as an Andrologist.

Responsibilities may include, but are not limited to:

- Performing diagnostic assays on human sperm specimens
- Preparing human sperm specimens for ART procedures, including intrauterine insemination, and
- Cryopreservation of human semen or sperm specimens

6 – Procedure Standards for all OHPs

Guidance to the Standard:

Standard 6.1 - The following clarification applies:

1) State of patient health, including co-morbidities (BMI, ASA physical status)

6 Procedure Standards for all OHPs

The ultimate judgment regarding the care of a particular patient and selection of procedure must be made by the physician considering all the circumstances presented in an individual case. Risk factors that should be considered as having the potential to jeopardize patient safety in an OHP include but should not be limited to:

1) State of patient health, including co-morbidities (ASA physical status)
2) Potential complication from a specific procedure
3) Complications in surgical management if more than one procedure is performed during a single operation
4) Anesthetic factors that place patient at higher risk
5) Necessity for prolonged recovery period
6) Duration of procedure
7) Availability of anti-hyperthermia measures
8) Anticipated blood loss
9) Hypothermia

6.1 Pre-Procedure Patient-Care Standards

Guidance to the Standard:

Standard 6.1.1 - The following clarification applies:

ii. appraise each patient's medical risk factors and capacity to undergo an anticipated procedure.

Standard 6.1.2 - The following clarifications applies:

Documentation:

All actions taken for pre-procedure patient care are entered in the patient record; informed consent, separate forms, e.g., consent for embryo freezing, consent for PGS, gamete shipping, legal forms, counseling forms, disposition of surplus gametes, tissues, and embryos if applicable, are placed in the patient record.

6.1 Pre-Procedure Patient-Care Standards

1. The physician must:
   i. assess the risks inherent in each procedure or combination of procedures to determine if the OHP setting is safe; and
   ii. appraise each patient's medical risk factors and capacity to undergo anesthesia
2. Documentation:

All actions taken for pre-procedure patient care are entered in the patient record; separate forms, e.g., consent form, are placed in the patient record.

6.2 Pre-Procedure Requirements: OHP Level 1

Guidance to the Standard

"BEFORE day of procedure" - a Nurse or Physician may be responsible for requirements listed in table 06.

"BEFORE or ON day of procedure" - The following clarification applies:

3. a) focused history and physical examination that includes findings indicating the rationale for the proposed procedure and risk factors

6.2 Pre-Procedure Requirements: OHP Level 1

Table 06: Pre-Procedure Requirements: OHP Level 1

Pre-Procedure Requirements: OHP Level 1	Responsibility
BEFORE day of procedure:	
1. Provide fasting instructions as required.	
2. Advise patient that a responsible adult should be accessible during the duration of the OHP stay.	
BEFORE or ON day of procedure:	
3. Conduct **pre-procedure assessment**, which includes, but is not limited to: a) focused history and physical examination that includes findings indicating the rationale for the proposed procedure b) blood pressure and pulse c) allergies.	Physician performing procedure
4. The physician is responsible for obtaining informed consent and a procedure consent form signed by the patient or substitute decision maker and witnessed.	
ON day of procedure:	
5. Complete admission assessment: Confirm baseline history and physical as in point 3 above.	

6.3 Pre-Procedure Requirements: OHP Levels 2 and 3

Guidance to the Standard

Standard 6.3.1 - The following clarification applies:

BMI and ASA classification

6.3 Pre-Procedure Requirements: OHP Levels 2 and 3

The physician providing anesthesia assigns an ASA classification for all prospective patients requiring anesthesia for OHP procedures; Class ASA4 and above are not generally acceptable for OHPs.

The pre-procedure anesthetic/sedation assessment includes but is not limited to the following:

1) ASA classification
2) a review of the patient's clinical record (including pre-procedure assessment)
3) an interview with the patient
4) a physical examination relative to anesthetic aspects of care
5) a review and ordering of tests as indicated
6) a review or request for medical consultations as necessary for patient assessment and planning of care
7) orders for pre-procedure preparation such as fasting, medication, or other instructions as indicated.

Guidance to the Standard

Table 08: Pre-Procedure Requirements

Table 08: Pre-Procedure Requirements

Where appropriate, the responsibility for the actions listed in the chart below may be performed by appropriately qualified providers under the direction of the Most Responsible Physician (MRP).

Pre-Procedure Requirements: OHP Levels 2 and 3

BEFORE day of procedure:	Responsibility
1. Provide fasting instructions as required for the procedure, specific conditions, (e.g., diabetes), and for medications the patient routinely takes (e.g., diabetic medications, antihypertensives, antiplatelets).	Physician performing procedure
2. Advise patients if they will require adult accompaniment on leaving OHP after the procedure.	
3. Advise patient that a responsible adult must be accessible during the duration of the OHP stay.	
BEFORE or ON day of procedure:	
4. Conduct pre-procedure assessment that includes, but is not limited to: a) history and physical examination that includes findings indicating the rationale for the proposed procedure b) all current medications (prescribed and non-traditional, e.g., herbal remedies) c) weight, height, body mass index (BMI), blood pressure, and pulse d) allergies e) ECG, laboratory tests, x-rays, pre-procedure consultation, and investigations (all as indicated).	Physician performing procedure
5. For patients with significant co-morbidities (including sleep apnea), arrange a consultation with an anesthesiologist, and other medical specialists as required, prior to procedure acceptance. 5.1 If classified as ASA3, patients may be accepted only if the disease entity could not reasonably be expected to be affected adversely by the anesthetic or procedure. 5.2 The physician and anesthesiologist should discuss all Class ASA3 cases well in advance of the scheduled procedure, with regard to the: a) pre-procedure assessment and care required, b) intra-procedure and post-procedure requirements, and c) appropriateness of OHP setting for the safe performance of the procedure.	Physician performing procedure or Physician providing anesthesia
6. Obtain informed consent and a procedural consent form signed by the patient. A rolling patient consent (which requires specific information to be documented) is suitable for the same procedure performed consecutively and should be documented in the patient's chart.	Physician performing procedure
7. Provide adequate explanation to the patient about the proposed anesthesia including anticipated outcome, significant risks, and alternatives available. This may be included in the procedure consent form.	Physician performing procedure or Physician providing
ON day of procedure:	
8. Complete admission assessment: Confirm pre-procedure anesthetic/sedation assessment (may be unnecessary if anesthesiologist conducts pre-procedure anesthetic/sedation assessment on same day as procedure).	Physician providing anesthesia
9. Complete admission assessment: Confirm baseline history and physical as in point 4 above; update if >14 days. Take vital signs (BP, pulse, respiration, oxygen saturation, temperature), and glucometer reading for diabetic patients where appropriate.	Health care provider

"ON day of procedure" - The following clarification applies:

8. Complete admission assessment: Confirm pre-procedure anesthetic/sedation assessment (may be unnecessary if sedation/procedure room nurse conducts pre-procedure anesthetic/sedation assessment on same day as procedure).

6.4 Verification Process

Guidance to the Standard

Standard 6.4.1 – The following clarification applies:

Procedures Included

Egg retrievals, sperm preparation, gamete culture, and embryo transfers all require verification process. This requires verification of the correct patient, partner and/or sperm sample, which includes, partner's demographics and/or donor ID/number at two different times and locations, as follows:

	When	Where
First verification	before entering the procedure room	the pre-procedure area
Second verification	during the time-out	in the procedure room

6.4 Verification Process

The verification process (prevention of wrong site, wrong procedure, or wrong patient) ensures that the correct patient has the correct procedure performed on the correct site.

NOTE: If the patient is unable to verify the information him/herself (e.g., minor, incompetent), the legal guardian/substitute decision maker provides and verifies the appropriate information.

1. Procedures Included

Procedures with any of the following components require a verification process; a) intravenous sedation; b) surgical incision (of any size); c) removal of tissue; d) primary procedure is itself an injection of any kind. This requires verification of the correct patient, procedure, and correct site at two different times and locations, as follows:

	When	Where
First verification	before entering the procedure room/ operating room	the pre-procedure area
Second verification	during the time-out	in the procedure room/ operating room

Note: Procedures exempted from site marking still require a verification process.

6.5 First Verification

Guidance to the Standard

Standard 6.5.3 - The following clarification applies:

The nurse or physician preparing the patient for the procedure confirms the patient identity, and procedure.

6.5 First Verification

1. The first verification takes place in the pre-procedure area.
2. The patient is awake and aware.
3. The nurse preparing the patient for the procedure:
   a) confirms the patient identity, procedure, site and/or side with the patient/substitute decision-maker/legal guardian
   b) documents the first verification on the Surgical Safety Checklist.

6.6 Second Verification

Guidance to the Standard

Standard 6.6.2 - The following clarification applies:

The patient and her partner (if applicable) are required to be awake.

Standard 6.6.3 – The following clarification applies:

The entire procedure team confirms the patient identity, procedure, consent and specimens according to their standard operating procedures.

The following additional requirement applies:

4. The physician performing an embryo transfer must verify the patient prior to the transfer.

6.6 Second Verification

1. The second verification must be conducted during the time-out in the location where the procedure takes place, immediately before starting the procedure.
2. The patient is not required to be awake.
3. The entire procedure team confirms the patient identity, procedure, site and/or side and acknowledges their agreement: nurse(s), attending physician, attending anesthesiologist (if applicable), and physician-assistant (if applicable).

6.7 Site Marking

This Standard does not apply.

6.7 Site Marking

1. Marking must take place with the patient awake and aware, if possible.
2. The physician performing the procedure marks at or near the incision/insertion site. Site- sensitive areas must be marked above or lateral to the procedure site (e.g., scrotal surgery sites are marked on the groin area on the appropriate side of the body; breast sites are marked on the breast or above the breast on the upper chest area).
3. Procedures involving right/left distinction or multiple structures (fingers, toes) must be marked.
4. The mark must be:
   a) placed using a permanent marker
   b) visible at the time of patient preparation and visible at time of incision
   c) explicit (e.g., initials) to indicate the intended site of incision or insertion or actual incision line.
5. Site marking is exempted in the following situations:
   a) The procedure requires a surgical measurement to the operative part when applied on an awake and oriented patient.
   b) Patient refuses to allow site marking. In this situation, a risk report is completed and placed in the patient's record.

6.8 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

Guidance to the Standard

Standard 6.8 - In addition to the listed requirements, the following additional requirement applies:

5. Other required documentation for IVF:

- Ovulation induction monitoring (stimulation sheet)
- Consent forms
- Procedure note with clear identification of physician performing the procedure
- Laboratory tracking document of personnel involved in each procedure

6.8 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

Requirements for managing patients undergoing sedation, regional anesthesia, or general anesthesia, are as follows. Note: See physician qualification as well.

1. If the physician administering the sedation or regional anesthesia is also performing the procedure, the patient must be attended by a second individual (physician, respiratory therapist, RN or anesthesia assistant) 1) who is NOT assisting in the procedure and 2) who is trained to monitor patients undergoing sedation or regional anesthesia.

1.1 The second physician, respiratory therapist, RN or anesthesia assistant shall hold ACLS (and PALS if pediatric patients are being treated) certification and the following skills:

1) assessing and maintaining patient airway
2) monitoring vital signs
3) venipuncture
4) administering medications as required
5) assisting in emergency procedures including the use of a bag-valve-mask device
6) documenting in the Anesthesia/Sedation Record

2. Note: If assistance is required during the procedure, a third HCP must be available. The person monitoring the anesthetic shall remain with the patient at all times throughout the duration of anesthetic care until the patient is transferred to the care of a recovery-area staff in the recovery area.

3. Patients shall be attended for the duration of the anesthetic care as follows:

3.1 O2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals. Capnography must be available at the premises for use, where appropriate, on patients receiving deep sedation. Capnography is always required for patients receiving general anesthesia as defined in section 3.2.

3.2 Pulse, blood pressure and electrocardiography must be in continuous use during the duration of anesthetic care. Heart rate and blood pressure shall be documented at least every 5 minutes. During sedation (see section 3.2) in healthy patients without cardiac disease and for whom no cardiovascular disturbance is anticipated, it may be acceptable to waive ECG monitoring as long as pulse oximetry is in continuous use and ECG monitoring is immediately available.

3.3 Audible and visual alarms must not be indefinitely disabled. The variable pitch pulse tone and the low-threshold alarm of the pulse oximeter and the capnograph alarm must give an audible and visual alarm. Variable pitch tone pulse oximeter must be clearly audible at all times.

4. The Anesthesia/Sedation Record is completed; it includes the following:
   1) pre-procedure anesthetic/sedation assessment
   2) all drugs administered including dose, time, and route of administration
   3) type and volume of fluids administered, and time of administration
   4) fluids lost (e.g., blood, urine) where it can be measured or estimated
   5) measurements made by the required monitors:
      - O2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA5 is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals
      - Pulse, blood pressure documented at least every 5 minutes until patient is recovered from sedation
   6) complications and incidents (if applicable)
   7) name of the physician responsible (and the name of the person monitoring the patient, if applicable)
   8) start and stop time for anesthesia/sedation care

Additional Requirements – Procedure Standards for Embryology

Verification

- Strict measures need to be taken to ensure safety and security of embryos/gametes, as well as the confidentiality of patient records.
- There should be at least 2 identification methods to assure all information pertaining to the patient material (e.g. sperm, oocytes, embryos, testicular or ovarian biopsy) is correct.
- The use of all biological material should be verified by two witnesses prior to their use.
- All information should be backed up to a secure secondary source.

7 – Infection Control

Guidance to the Standard

Standard 7 - In addition to the Standard, the following clarification applies:

Facilities offering Assisted Reproductive Technology (ART) laboratory services may use soap and water as an alternative for hand hygiene.

7 Infection Control

The CPSO, in partnership with Public Health Ontario (PHO), have developed accepted standards of practice for OHPs and physician offices for infection control. The document can be found at the following link: www.publichealthontario.ca/ClinicalPractice

Medical Directors should consult the specific section of the PHO website for the following information, which form part of the OHP standards expectations. Medical Directors are responsible to ensure periodic reviews of the CPSO and PHO website documents to stay current with standards for infection prevention and control, and ensure compliance with these recommendations.

OHPs shall adhere to the following:

1) Accepted standard(s) of infection control practices that are pertinent to the specific procedures performed at the OHP.
2) The Routine Practice approach to infection control. According to the concept of Routine Practices, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.
3) Actions that minimize risk of infection in the operating room:
   a) adherence to proper use of disinfectants
   b) proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors)
   c) proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms)
   d) prompt management of water intrusion into OHP structural elements.
4) Accepted standards of handling regulated waste. “Regulated Waste” means:
   a) liquid or semi-liquid or other potential infectious material
   b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed
   c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling
   d) contaminated sharps
   e) pathological and microbiological wastes containing blood or other potentially infectious materials.

8.1 – Monitoring Quality of Care

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 (see 8.2)

   The suggested protocol is, annually, random selection of 5-10 patient records to review:
   i) record 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).

Guidance to the Standard

Standard 8.1 - The following addition applies:

6) The most recent BORN standardized reports or dashboard data for all cycles started submitted by the premises must be made available to the assessor for review (as requested) or this data must be submitted to CPSO, which includes data on all cycles (funded or unfunded).

Additional Requirements – Quality Assurance (QA)

1. Monitoring OHP Laboratory Activity

1) Embryology Laboratory quality monitoring
2) Andrology Laboratory quality monitoring
    a) IVF andrology services
    b) IUI andrology services
3) Biochemistry Laboratory quality monitoring (if applicable)
4) Documentation of lab errors and near misses
5) Documentation of the numbers and types of laboratory procedures performed: including any significant increase/decrease

2. Quality Advisor Laboratory Activities

Premises shall appoint a Quality Advisor for laboratory activities. The Laboratory Quality Advisor shall report to the Medical Director on a regular basis of no less than every 3 months and provide an annual report in writing. The annual report on quality review should include a summary of standard outcome measures tracked as per the BORN database, and all Tier 1 and 2 adverse events as defined by the CPSO.

3. Outcomes

The recording, analysis and reporting of essential outcome measures is a reflection of the center's commitment to providing quality patient care. The process provides road signs and future direction for improvement within the center.

A) Monitoring Clinic Referral Pre-Screening (Barriers to Access/Gatekeeping)

The Medical Director shall review and document:

- Patient criteria for acceptance for consultation
- Wait times/ waiting lists for first appointments at the premises as well as for first cycles for each of OI, IUI, IVF treatments
- Any referral for treatment rejections and the reasons for rejection

B) Patient Population Monitoring

The following shall be documented on an annual basis for all patients seen in the clinic:

- Age
- LHIN of residence (Address and postal code will provide LHIN of residence information)
- Primary diagnoses/reason(s) for treatment

C) Intrauterine Insemination (IUI)

- When available, the most recent Better Outcomes Registry and Network (BORN) standardized reports and dashboard data submitted by the premises must be made available to the assessor for review (as requested). Premises should visit the BORN website for further information: https://www.bornontario.ca/ . Until the BORN reports are available, the premises shall provide those outcome reports that are used in its quality assurance program.

D) Fertility Preservation

- The most recent Better Outcomes Registry and Network (BORN) dashboard data submitted by the premises must be made available to the assessor for review (as requested). Premises should visit the BORN website for further information: https://www.bornontario.ca/

E) In Vitro Fertilization (IVF)

- The most recent Better Outcomes Registry and Network (BORN) dashboard data submitted by the premises must be made available to the assessor for review (as requested). Premises should visit the BORN website for further information: https://www.bornontario.ca/

PART II: Ovulation induction/ Intracervical insemination/ Intrauterine insemination (OI/ICI/IUI) units

NOTE: *Within each Part of this document, the content is further organized as follows:*

a) Specific sections of the core OHPIP Standards have been clarified to show how they uniquely apply to fertility services premises – as such, the numbered sub-sections mirror the numbering in the core OHPIP Standards.

b) Additional requirements with which premises must comply.

This Guide should be considered a required companion document to the core OHPIP Standards for practitioners. Premises must also comply where appropriate with all other requirements listed in the core OHPIP Standards.

2.2.6 – Policies and Procedures

2.2.6.1.1 Administrative

Guidance to the Standard

d) Overnight stays - does not apply.

2.2.6 OHP Policies and Procedures

1. The Medical Director is responsible for the regular review, update, and implementation of OHP policies and procedures, which must address the following areas:

2.2.6.1 Administrative:

a) responsibility for developing and maintaining the policy and procedure manual
b) organizational chart
c) scope and limitations of OHP services provided
d) overnight stays, if applicable.

e) ensuring that records kept for each RHP working in the OHP are current and include qualifications, relevant experience, and relevant hospital privileges as appropriate to the RHP.

f) ensuring all physicians performing OHP procedures at the premises have provided online notification to satisfy the regulation requirements (see section 2.2.1), and documentation verifying approval (emails from College staff) is on file.

2.2.6.1.5 Procedures

Guidance to the Standard

In addition to the procedures listed, the following clarification and additions apply:

h) Medical and Laboratory Directives

q) Handling of human gametes (sperm) in accordance with current CSA Standards

r) Urgent transfer of cryopreserved sperm for assisted human reproduction

2.2.6.1.5 Procedures:
a) Adverse events: monitoring, reporting, and reviewing
b) Adverse events: response to an adverse event
c) Combustible and Volatile Materials
d) Delegating controlled acts
e) Equipment: routine maintenance and calibration
f) Infection control, including staff responsibilities in relation to the Occupational Health and Safety Act
g) Medications handling and inventory
h) Medical Directives
i) Patient booking system
j) Detailed and clear patient selection/admission/exclusion criteria for services provided at the OHP
k) Patient consent (written or verbal) based on the scope of the OHP practice
l) Patient Preparation for OHP procedures
m) Response to Latex Allergies
n) Safety precautions regarding electrical, mechanical, fire, and internal disaster.
o) Urgent transfer of patients (see Section 2.2.6.1.3)
p) Waste and garbage disposal

Additional Requirements – OHP Policies and Procedures

The Medical Director shall ensure that there are separate policies and procedures documented for each of the clinic subsections (as applicable):

Policies and Procedures (P&P) Manuals for Clinical Subsections

It is recommended that the most recent version of Canadian Fertility and Andrology Society (CFAS) guidelines as they apply to assisted human reproduction be included in P&P manuals, where applicable.

1) Physician staff (Including for OI, ICI, and IUI Procedures)
2) Nursing staff – should include the policies and procedures governing safe nursing practice in an OI, ICI, and IUI clinic
3) Ultrasound Services (If an Independent Health Facilities (IHF) Ultrasound licenced facility is within the premises, then the manual(s) related to ultrasound licence of an IHF is/are acceptable)
4) Biochemistry Laboratory
5) Andrology Laboratory (Including IUI procedures and diagnostic testing)
6) Information Technology (IT) (to include, but not limited to, EMR services, Data Protection and Privacy, Equipment Maintenance)
7) Housekeeping
8) Reprocessing
9) Administration
10) Research (basic and/or clinical)
11) Counselling (if located within the premises)
12) Ethics oversight (including ethics committee if applicable)
13) Quality Assurance

4.1 – General Physical Standards

Guidance to the Standard

Layout, Standard 4.1.5.2 - The following clarifications apply:

c) Does not apply

g) Does not apply

4.1 General Physical Standards

		Level 1	Level 2	Level 3
1	**Building Codes**	OHP site complies with all applicable building codes including fire safety requirements.		
2	**Electrical**	1. All electrical devices are certified by CSA or licensed for use in Canada. 2. Emergency power supply can provide for safely completing the procedure and recovering the patient.		
3	**Access**	1. Access for persons with disabilities complies with provincial legislation and municipal bylaws. 2. Doors and corridors can safely accommodate stretchers and wheelchairs.		
4	**Size**	OHP size is adequate for all procedures to be performed.		
5	**Layout**	1. Layout facilitates safe patient care and patient flow. 2. These areas are functionally separate: a) administration and patient-waiting area b) procedure room and/or operating room c) recovery area d) clean utility area e) dirty utility room f) reprocessing room g) endoscope cabinet h) staff change room and staff room.		
6	**Emergency Measures**	Provisions are in place to ensure 1. The safe evacuation of patients and staff in case of an emergency, i.e., stretchers, wheelchairs, or other adequate methods of transport are available, and 2. There is appropriate access to the patient for an ambulance to transfer the patient to a hospital.		

4.2 Procedure Room/Operating Room Physical Standards

Guidance to the Standard

Physical Requirements, Standard 4.2.1.1 is clarified as follows:

> c) immediate access to hand-washing or hand hygiene facilities and proper towel disposal

Ventilation, Standard 4.2.2 – The following clarification applies:

> 2 and 3 – do not apply.

Equipment, Standard 4.2.3 - The following clarifications apply:

> 2 d) - does not apply
>
> 3 b) and c) – do not apply
>
> 3 e) table/chair that permits gynecological access
>
> 3 f) table/chair/stretcher that accommodates procedures performed and provides for adequate range of movement for procedures
>
> 3 g) – does not apply

4.2 Procedure Room/Operating Room Physical Standards

	Level 1	Level 2	Level 3
1 Physical Requirements	1. All OHP levels provide: a) lighting as required for the specific procedure b) floors, walls and ceilings that can be cleaned to meet infection control requirements c) immediate access to hand-washing facilities and proper towel disposal d) openings to the outside effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current or other effective means 2. Space can accommodate equipment and staff required for the procedure. 3. Space allows the physician and assisting staff, when sterile, to move around the OR/procedure table with access to both sides of the patient, without contamination.		

	Level 1	Level 2	Level 3
2 Ventilation	1. Ventilation must ensure patient and staff comfort; and fulfill occupational health and safety requirements. 2. Where applicable, ventilation and air circulation should be augmented to meet manufacturer's standards and address procedure-related air-quality issues; e.g., cautery smoke, endoscopy, disinfecting agents (e.g., Glutacide venting is separate from the other internal ventilation). 3. Where gas sterilization is used, a positive pressure outbound system is used, vented directly to the outside.		

	Level 1	Level 2	Level 3
3 Equipment	1. Medical equipment must be maintained and inspected yearly by a qualified biomedical technician. 2. Related documentation for all equipment is available: a) equipment operating manuals b) equipment maintenance contracts with an independent and certified biomedical technician c)log for maintenance of all medical devices d) Equipment necessary for emergency situations (i.e. Defibrillators, oxygen supply, suction) should be inspected on a weekly basis and documented. 3. The following equipment is provided: a) cleaning equipment as required for the specific procedure b) accessible anesthetic material and equipment c) blood pressure and oxygen saturation monitoring equipment d) sterile supplies and instruments e) table/chair that permits patient restraints and Trendelenberg positioning (level 2 &3) f) table/chair/stretcher that accommodates procedures performed and provides for adequate range of movement for anesthetic procedures g) suction equipment and backup suction, for anesthesia provider's exclusive use.		

Anesthetic and Ancillary Equipment

4.2.4 – Does not apply.

4.2 Procedure Room/Operating Room Physical Standards (continued)

4 Anesthetic and Ancillary Equipment	Level 1 NA		1. Both a) anesthetic and ancillary equipment (selection, installation, maintenance) and b) medical compressed gases and pipelines must comply with: • Canadian Standards Association (CSA) or licensed for use in Canada, and • Specific applicable recommendations arising from provincial legislation or as identified in other CPSO requirements 2. A second supply of (full cylinder) oxygen capable of delivering a regulated flow must be present.
	Level 1 NA	Level 2 NA	3. Level 3 OHP provides: a) anesthetic machine b) anesthetic equipment/drug cart.

4.3 Recovery-Area Physical Standards

Guidance to the Standard

This Standard does not apply.

4.3 Recovery-Area Physical Standards

Table 05: Recovery-Area Physical Standards

	Level 1	Level 2	Level 3
1 Physical Requirements	1. A sink for hand washing is accessible.		
2 Size and Layout	Level 1 NA	1. The size of the recovery area depends on planned use: it must accommodate the volume of patients expected for a minimum of two hours operating room time, i.e., • 1 hour procedure = 2 patients • 0.5 hour procedure = 4 patients. 2. The recovery area allows for transfer of patients to/from a stretcher and performance of emergency procedures.	
3 Equipment	Level 1 NA	Monitoring, suction, oxygen, and bag-valve mask devices, intravenous and other medical supplies are immediately available.	

4.4 General Medication Standards

Guidance to the Standard

Standard 4.4.1 – The following addition applies:

j) if dispensed under the authority of a physician, medication(s) used in ovulation induction or controlled ovarian hyperstimulation prior to IUI or IVF and after discharge from the procedure must be stored, dispensed and discarded in keeping with the manufacturer's requirements, good medical practice and accounted for on a daily basis. Once dispensed medication leaves the clinic it may not be returned into the medication inventory of the clinic.

Standard 4.4.2 - Does not apply.

4.4 General Medication Standards

1. OHPs should:

a) maintain a general medication inventory record

b) periodically inspect all medications for viability

c) date multidose vials of medication on opening and dispose according to manufacturer's guidelines

d) label medications in accordance with the Food and Drug Act (FDA) and the Controlled Drugs and Substances Act (CDSA) and its regulations

e) store medications:

i) according to the manufacturer's recommendations (e.g., refrigeration if required)

ii) in a manner suitable for security and restocking

f) store emergency drugs in a common location. In facilities where procedures are done in multiple procedure rooms, a crash cart is advisable

g) document administration of medications in the patient record

h) dispense medications at discharge accompanied by verbal and written instructions that are given to the patient and/or accompanying adult

i) make available resources to determine appropriate drug dosages and usage.

2. If services are provided to infants and children, the required drugs must be available and appropriate for that population.

4.5 Controlled Substances Standards

Guidance to the Standard

This Standard (not shown on the right side) does not apply.

4.6 Drugs for Resuscitation

Guidance to the Standard:

This Standard (not shown on the right side) does not apply.

4.7 Monitoring and Resuscitation Requirements

Guidance to the Standard:

This Standard (not shown on the right side) does not apply.

5.6 – Nurse Qualifications

Guidance to the Standard

Standard 5.6.1 - The following clarifications apply:

b) additional training and appropriate experience as required for procedures performed including assisting with IUI procedures, counselling and supporting patients receiving treatments, performing delegated medical acts, patient teaching, recognition and treatment of complications e.g., OHSS and documentation of all interactions with patients.

d) Does not apply

Standard 5.6.2 – Does not apply.

5.6 Nurse Qualifications

1. Registered nurses (RNs) and registered practical nurses (RPNs) working within their scope of practice in OHPs must hold:
   a) current registration with the College of Nurses of Ontario
   b) additional training and appropriate experience as required for procedures performed
   c) current BLS certification
   d) must have current ACLS if administering sedation to, monitoring or recovering patients (RNs only).
2. Registered Nurses (RNs) working with a pediatric population (14 years and younger), who are involved in monitoring, administering sedation or recovering patients must maintain a current PALS certification.

Additional Requirements – OHP Staff Qualifications - Laboratory Staff Qualifications

Some larger Assisted Reproductive Technology (ART) programmes, or specialized IUI/donor sperm programmes, have dedicated ART Andrology Laboratory staff members who do not have embryology responsibilities.

- additional appropriate andrology training and experience as required for sperm sample assessment and preparation that is consistent with the clinic's standard operating procedures.

6.1 Pre–Procedure Patient Care Standards

Guidance to the Standard:

Standard 6.1.1 - The following clarification applies:

II. appraise each patient's medical risk factors and capacity to undergo anticipated procedure.

6.1 Pre-Procedure Patient-Care Standards

1. The physician must:
   I. assess the risks inherent in each procedure or combination of procedures to determine if the OHP setting is safe; and
   II. appraise each patient's medical risk factors and capacity to undergo anesthesia

2. Documentation:

   All actions taken for pre-procedure patient care are entered in the patient record; separate forms, e.g., consent form, are placed in the patient record.

6.3 Pre-Procedure Requirements

Guidance to the Standard:

This Standard does not apply, as there is no anesthetic/sedation for this procedure.

6.3 Pre-Procedure Requirements: OHP Levels 2 and 3

The physician providing anesthesia assigns an ASA classification for all prospective patients requiring anesthesia for OHP procedures; Class ASA4 and above are not generally acceptable for OHPs.

The pre-procedure anesthetic/sedation assessment includes but is not limited to the following:

1) ASA classification
2) a review of the patient's clinical record (including pre-procedure assessment)
3) an interview with the patient
4) a physical examination relative to anesthetic aspects of care
5) a review and ordering of tests as indicated
6) a review or request for medical consultations as necessary for patient assessment and planning of care
7) orders for pre-procedure preparation such as fasting, medication, or other instructions as indicated.

6.4 Verification Process

Guidance to the Standard

Standard 6.4.1 - The following clarification applies:

Procedures Included

Sperm preparation requires verification process. This requires verification of the correct patient, partner and/or sperm sample, which includes, partner's demographics and/or donor ID/number at two different times and locations, as follows:

	When	Where
First verification	before entering the procedure room	the pre-procedure area
Second verification	during the time-out	in the procedure room

6.4 Verification Process

The verification process (prevention of wrong site, wrong procedure, or wrong patient) ensures that the correct patient has the correct procedure performed on the correct site.

NOTE: If the patient is unable to verify the information him/herself (e.g., minor, incompetent), the legal guardian/substitute decision maker provides and verifies the appropriate information.

1. Procedures Included

Procedures with any of the following components require a verification process; a) intravenous sedation; b) surgical incision (of any size); c) removal of tissue; d) primary procedure is itself an injection of any kind. This requires verification of the correct patient, procedure, and correct site at two different times and locations, as follows:

	When	Where
First verification	before entering the procedure room/ operating room	the pre-procedure area
Second verification	during the time-out	in the procedure room/operating room

Note: Procedures exempted from site marking still require a verification process.

6.5 First Verification

Guidance to the Standard

Standard 6.5.3 - The following clarifications apply:

The nurse or physician preparing the patient for the procedure confirms the patient identity, and procedure.

b) Does not apply.

6.5 First Verification

1. The first verification takes place in the pre-procedure area.
2. The patient is awake and aware.
3. The nurse preparing the patient for the procedure:

a) confirms the patient identity, procedure, site and/or side with the patient/substitute decision-maker/legal guardian

b) documents the first verification on the Surgical Safety Checklist.

6.6 Second Verification

Guidance to the Standard

The following clarifications apply:

2. Does not apply.

3. The entire procedure team confirms the patient identity, procedure, consent and specimens according to their standard operating procedures.

The following **additions** apply:

4. The physician performing an insemination must verify the patient prior to the procedure.

There should be a standard operating procedure for identity verification of the sperm sample for all procedures.

6.6 Second Verification

1. The second verification must be conducted during the time-out in the location where the procedure takes place, immediately before starting the procedure.
2. The patient is not required to be awake.
3. The entire procedure team confirms the patient identity, procedure, site and/or side and acknowledges their agreement: nurse(s), attending physician, attending anesthesiologist (if applicable), and physician-assistant (if applicable).

6.7 Site Marking

This Standard does not apply.

6.7 Site Marking

1. Marking must take place with the patient awake and aware, if possible.
2. The physician performing the procedure marks at or near the incision/insertion site. Site- sensitive areas must be marked above or lateral to the procedure site (e.g., scrotal surgery sites are marked on the groin area on the appropriate side of the body; breast sites are marked on the breast or above the breast on the upper chest area).
3. Procedures involving right/left distinction or multiple structures (fingers, toes) must be marked.
4. The mark must be:
   a) placed using a permanent marker
   b) visible at the time of patient preparation and visible at time of incision
   c) explicit (e.g., initials) to indicate the intended site of incision or insertion or actual incision line.
5. Site marking is exempted in the following situations:
   a) The procedure requires a surgical measurement to the operative part when applied on an awake and oriented patient.
   b) Patient refuses to allow site marking. In this situation, a risk report is completed and placed in the patient's record.

6.8 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

This Standard (not shown) does not apply.

6.9 Post-Procedure Patient Care

This Standard (not shown) does not apply.

6.10 Patient Discharge/Post Procedure Care

Guidance to the Standard

Standard 6.10.1 to 6.10.4 – do not apply.

The following does apply:

Appropriate post-procedure instructions are given to the patient. Such as any side effects of the procedure or medication.

6.10 Patient Discharge

For OHP levels 2 and 3:

1. An anesthesiologist or physician is responsible for writing the discharge order. However, the actual decision for discharge from the recovery area must be based on discharge criteria using an objective scoring system; the decision can be delegated to recovery-area staff.
2. All patients should be accompanied by an adult when leaving the OHP. Patients having received sedation or general anesthesia must be accompanied by a responsible adult.
3. Appropriate verbal and written post-discharge instructions are given to the patient and the accompanying adult.
4. The patient and accompanying adult are instructed to notify the OHP of any unexpected admission to a hospital within 10 days of the procedure.

Additional Requirements – Procedure Standards for Gonadotropin Stimulation for Ovulation Induction

The physician prescribing gonadotropins should have the appropriate training and/or experience, including a plan to deal with potential complications inherent to the use of gonadotropins, including an established relationship with an IVF centre (see Physician Qualifications section in core OHPIP Standards).

7 – Infection Control

Guidance to the Standard

In addition to the Standard, the following clarification applies:

Facilities offering Assisted Reproductive Technology (ART) laboratory services may use soap and water as an alternative for hand hygiene.

7 Infection Control

The CPSO, in partnership with Public Health Ontario (PHO), have developed accepted standards of practice for OHPs and physician offices for infection control. The document can be found at the following link: www.publichealthontario.ca/ClinicalPractice

Medical Directors should consult the specific section of the PHO website for the following information, which form part of the OHP standards expectations. Medical Directors are responsible to ensure periodic reviews of the CPSO and PHO website documents to stay current with standards for infection prevention and control, and ensure compliance with these recommendations.

OHPs shall adhere to the following:

1) Accepted standard(s) of infection control practices that are pertinent to the specific procedures performed at the OHP.
2) The Routine Practice approach to infection control. According to the concept of Routine Practices, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.
3) Actions that minimize risk of infection in the operating room:
   a) adherence to proper use of disinfectants
   b) proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors)
   c) proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms)
   d) prompt management of water intrusion into OHP structural elements.
4) Accepted standards of handling regulated waste. "Regulated Waste" means:
   a) liquid or semi-liquid or other potential infectious material
   b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed
   c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling
   d) contaminated sharps
   e) pathological and microbiological wastes containing blood or other potentially infectious materials.

8.1 – Monitoring Quality of Care

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 (see 8.2)

The suggested protocol is, annually, random selection of 5-10 patient records to review:

   i) record 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).

Guidance to the Standard

Standard 8.1 - The following addition applies:

6) When available, the most recent BORN standardized reports or dashboard data for all cycles started submitted by the premises must be made available to the assessor for review (as requested) or this data must be submitted to CPSO, which includes data on all cycles (funded or unfunded).

Additional Requirements – Quality Assurance

In situations where an OI/ICI/IUI center provides its own laboratory services as part of the OI/ICI/IUI treatment, the center is expected to provide evidence of quality monitoring as follows:

1. Monitoring OHP Laboratory Activity (if applicable)

1) Andrology Laboratory quality monitoring
2) Biochemistry Laboratory quality monitoring
3) Documentation of lab errors and near misses
4) Documentation of the numbers and types of laboratory procedures performed: including any significant increase/decrease

2. Quality Control

When available, the most recent BORN standardized reports and dashboard data submitted by the premises must be made available to the assessor for review (as requested). Until such time as these reports are finalized, the clinic must provide to the assessor those data that are used in the facility's quality assurance program.

Discipline Committee
Report of Completed Cases - May 2017

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between February 4, 2017 and May 5, 2017. The decisions are organized according to category, and then listed alphabetically by physician last name.

Incompetence - 3 cases

1. Dr. P.M. Fenton

Name:	Dr. Peter Michael Fenton
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	March 20, 2017
Written Decision Date:	April 21, 2017

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Fenton received his certificate of registration authorizing independent practice in Ontario in June 1992. At all relevant times, Dr. Fenton practised in a solo family medicine practice in Toronto.

After receiving a public complaint in June 2013 and information from a physician in July 2014 expressing concern regarding Dr. Fenton's prescribing to a patient, the College conducted an investigation into Dr. Fenton's prescribing practices.
The College retained a family physician expert who opined that Dr. Fenton's care and treatment displayed a lack of knowledge, skill and judgment and that he failed to meet the standard of practice in the following respects:

- His charting is completely inadequate in terms of lack of substantive content for patient encounters, lack of useful cumulative patient profiles, including current medication lists, and when screening for controlled substances is begun in the fall of 2014, there is evidence of lack of insightful enquiry. Referral letters to consultants are consistently insufficient in content;
- There is a widespread lack of preventative care and chronic disease management;
- His acute presentation management as presented in his charts is generally superficial and treatment is not evidence based. Referrals are made at patient's request with little documentation of thought of possible differential diagnoses;
- His failure to acknowledge and appropriately document follow up concerns such as systolic blood pressure greater than 200 mm Hg and a neck mass growing in size could be considered as risks to the patient;
- His EMR is not used effectively for medication management, cumulative patient profiles, or lab result management;

- He prescribes controlled substances in excess quantities in many charts and there is lack of knowledge of guidelines for safe prescribing as outlined in the CPSO Policy #8-12 regarding prescribing of medications and the Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non Cancer Pain. He does not have a solid understanding of the use of urine toxicology screening for controlled substances;
- There is evidence that he continues prescribing controlled substances for patients with possible adverse events, which may be directly related to the medication prescribed. Poly-pharmacy is often seen, and may be causing adverse effects such as decreased cognitive functioning in the elderly or insomnia in the case of excessive stimulant doses; and
- He appears to lack the professionalism to practice evidence based medicine, which he appears to have knowledge of, opting instead to prescribe as per the wishes of his "difficult" "demanding" patients, as he describes them.

In the course of the investigation, Dr. Fenton obtained a copy of the expert's report, which contained the initials, date of birth and sex for 26 of Dr. Fenton's patients together with a detailed review of the treatment and care received. Dr. Fenton showed the expert report to at least one of his patients, including a patient who was not the subject of the expert's review.

Dr. Fenton is incompetent and failed to maintain the standard of practice of the profession with respect to his prescribing of narcotic drugs, narcotic preparations, controlled drugs, Benzodiazepines and other targeted substances and all other monitored drugs ("Controlled Substances"), as described above.

Dr. Fenton also failed to maintain the standard of practice of the profession as described above, including by failing to follow appropriate practices related to chronic disease management and preventative care; and failing to maintain appropriate clinical notes and records.

Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in failing to preserve and maintain patient confidentiality during the College's investigation.

<u>Investigation regarding Patient A</u>

On December 8, 2014, the College received a public complaint from Patient A, who had been a patient of Dr. Fenton's for approximately five years and whose care included treatment for chronic pain and anxiety. Dr. Fenton dismissed Patient A from his practice in late November 2014.

The College expert opined that Dr. Fenton's medical records demonstrate a significant lack of knowledge, skill and judgment in medical record keeping and controlled substance prescribing, and do not meet the standard of care of the profession for a family physician as follows:

- Dr. Fenton's recorded histories are often non-existent and lack detail to understand the patient's story. His documented physical examinations are either lacking entirely or insufficient for the complex chronic pain condition this patient reports. No investigations are done with respect to Patient A's physical pain or anxiety conditions. Impressions and management plans are not outlined regularly. Not all prescriptions given are recorded in the EMR. Rational for the prescription of medications (choice of drug, dose or quantity) including many controlled substances is not found in the medical record. CPP was not completed until after the patient was discharged from the practice;
- Dr. Fenton's prescribing of controlled substances including narcotics, benzodiazepines and stimulants is excessive and without documented justification;
- Prescription information from the NMS database and Dr. Fenton's chart calculate over 1000 morphine equivalents daily well in excess of "watchful dose" limits. There is a lack of evidence of application of recognized controlled substance prescribing guidelines. There is no adequate discussion of side effects, risks and alternative analgesic options. There are no clear treatment goals documented. There is no documented indication for either stimulant or sedative medication, or discussion about the use [of] both categories of medication being prescribed concurrently. There is no supporting documentation of underlying diagnoses to support the use of these medications. There is no supporting evidence of favourable clinical outcomes as a result of these treatments;
- Dr. Fenton appropriately advised Patient A that because of repeated breaches of their opiate treatment agreement, he would no longer continue to prescribe controlled substances for Patient A. This would be partially considered to be within the standard of care for termination of a physician patient relationship as per CPSO Policy, however the policy also indicates a copy of this letter should be sent by registered mail to the patient and a copy be in the patient record. There is no documentation in the chart or in the patient complaint that the patient received such a letter. In addition, in considering termination of the patient physician relationship, there is no evidence that arrangement for any consultations with a pain clinic or alternate provider were made which would also be within the standard of care in family medicine. More importantly there is no evidence that strategies of tapering doses of her various medications or dispensing smaller quantities at one time, which would have potentially mitigated some of her risk having been taking such high doses of narcotics and sedatives prior to her dismissal.

Dr. Fenton is incompetent and failed to maintain the standard of practice in his care and treatment of Patient A, as described above, including his failure to follow the College's Policy regarding Ending the Physician-Patient Relationship.

Investigation Regarding Patient B

On January 22, 2015, the College received a public complaint from Patient B who had been a patient of Dr. Fenton's from approximately July 2008 until November 2014. Patient B's medical history includes hypertension, hypercholesterolemia, diabetes and chronic pain.

The College expert opined that Dr. Fenton's care of Patient B did not meet the standard of care, including in his record keeping, his chronic disease management and his follow up on abnormal test results and suggestions of consultants. Specifically, the expert noted the following deficiencies:

- There is evidence that medications are prescribed but not recorded within the EMR. A large gap exists in that there is no evidence of chronic disease management between the periods June 2013 to May 2014. There is evidence that abnormal test results and suggestions of consultant (in this case the ER doctor) are not followed up;
- Dr. Fenton's treatment of [Patient B's] hypertension is not clear from the documentation found in the chart in that a complete list of medications being prescribed is not found in the record provided. It is unclear as to when or why hydrochlorothiazide appears to have been added. There is no documented risk stratification. There is no assessment of possible end organ damage. The management of hypertension and its risks as documented does not meet the standard of care as expected of a competent practitioner in Family Medicine and demonstrates a lack of skill and judgment in the management of this chronic disease;
- The diagnosis and management of diabetes by Dr. Fenton does not follow the current guidelines of the Canadian Diabetic Association. Dr. Fenton appears from the chart to have made the diagnosis of diabetes based on a single laboratory reading of HbA1c equaling 0.065. There is no discussion of repeating this test on a different day as recommended. Once diagnosed, appropriate treatment based on the information provided would begin with discussion of lifestyle management of weight loss, exercise, and dietary habits including referral to allied health professionals for education would be the expected standard of care. The only documentation in this regard is "weight loss discussed" <u>following</u> the visit where metformin therapy was instituted;
- There is mention in the chart provided of discussion of lipid management, however targets were not identified. Again there is no evidence of risk stratification to guide treatment decisions as outlined in current guidelines. The patient appears to have been put on sub therapeutic doses of atorvastatin and had Ezetrol added in 2012, with no follow up to document response to treatment, or potential side effects until 2014. There is no discussion documented regarding maximizing the dose of the statin, or reasons why this would not be appropriate, before starting another class of medication which is considered standard of care by current guidelines. There is no discussion of lipid management following the lab work done in May 2014, which included a lipid profile and Dr. Fenton's diagnosis of diabetes.

On December 17, 2015, the College's investigator received a call from Patient B who described running into Dr. Fenton recently at a Tim Horton's in their neighbourhood. During that encounter, Dr. Fenton asked Patient B to call the College and drop the investigation regarding Dr. Fenton. Patient B asked the College investigator to contact

Dr. Fenton and request that Dr. Fenton not approach him in the future if they see each other in the community.

Dr. Fenton failed to maintain the standard of practice of the profession in his care and treatment of Patient B, as described above, including his failure to follow the College's Policy regarding Test Results Management.

Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in his failure to transfer Patient B's medical chart in a timely manner; and his communications with Patient B regarding his complaint to the College and his request for Patient B to withdraw his complaint.

Investigation Regarding Patient C

On July 28, 2015, the College received a public complaint from Patient C's lawyer who was representing Patient C with respect to an insurance claim and accident benefits arising out of a motor vehicle accident in 2010. Patient C was a patient of Dr. Fenton's since approximately 2009. Between August 2011 and July 2015, Patient C's lawyer made several attempts to obtain Patient C's medical chart from Dr. Fenton. Despite multiple requests by the College, the EMR and the paper charts were provided to Patient C's lawyer for the first time in March 2017.

On January 25, 2016, Patient C had an appointment with Dr. Fenton. During that appointment, Dr. Fenton asked Patient C to contact the College and tell them that Patient C had no problem with Dr. Fenton as a doctor. Dr. Fenton told Patient C that it would be helpful if Patient C could call the College and tell them he had no concerns. Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in his failure to transfer Patient C's medical chart in a timely manner; his failure to respond to inquiries from the College within a reasonable time; and his communications with Patient C regarding his complaint to the College and his request for Patient C to call the College and tell them he had no concerns with Dr. Fenton as a doctor.

Investigation Regarding Patient D

On February 19, 2016, the College received a public complaint from a family member of Patient D expressing concern regarding the care provided by Dr. Fenton to Patient D, who had been a patient of Dr. Fenton's since approximately April 2010.

The College retained a family physician expert who opined as follows:

- Dr. Fenton's practice does not meet the standard for record keeping. This includes the lack of an up to date Cumulative Patient Profile, lack of documentation to demonstrate physical findings, differential diagnoses and well thought out treatment plans. His referral notes to specialists were incomplete;

- Dr. Fenton's practice does not meet the standard for the safe and effective use of opioids in the management of chronic non cancer pain. He documented risk factors for addiction and adverse events (alcohol abuse, lorazepam abuse) and did not apply harm reduction strategies such as tapering Benzodiazepines; weekly prescribing; referral to a pain specialist;
- Dr. Fenton's practice does not meet the standard of care for the safe and effective use of Benzodiazepines in the management of anxiety and insomnia. This patient became dependent on lorazepam. She was falling, complaining of general malaise, dizziness, and tremor. Medication adverse effects were never documented as a possible contributing factor to her progressive debility.

The College expert further opined that Dr. Fenton's care and treatment of Patient D displayed a lack of knowledge, skill and judgment as follows:

- Lack of knowledge: Dr. Fenton knew Patient D had a history of alcohol abuse. He documented Patient D's dependence and abuse of lorazepam. He continued to prescribe as Patient D became older and frailer (21 Dec 2015- "needs more help now every 2 weeks"), experiencing episodes of dizziness, poor balance, low appetite and multiple falls. There is no evidence that he has a comprehensive and organized approach to managing chronic non-malignant pain with resources other than controlled drugs;
- Lack of skill: Dr. Fenton continued to prescribe opioids and benzodiazepines for Patient D without taking any extra precautions to manage the risk of potential abuse. He did not refer Patient D to a pain or addiction specialist. He did not reduce her prescribed doses in an attempt to safely wean her from these drugs. There is no evidence that he had a thoughtful approach to the overall health risk management of this frail elderly woman with multiple chronic conditions;
- Lack of judgment: Dr. Fenton acceded to [Patient D's] demands for stronger pain medication without establishing any safeguards against increasing dependence and adverse effects. He cautioned Patient D about drug and alcohol use but he took no effective steps to treat these conditions or reduce harm from his part, which was the prescribing. Dr. Fenton put the responsibility for managing dependence and abuse of controlled drugs onto his patient despite clear ongoing indications that Patient D was not taking the best self-care.

The expert concluded that "it is reasonably foreseeable that if Patient D's prescribed medications and alcohol use continue Patient D will experience serious adverse health outcomes from some kind of in home accident, a fall or an overdose." Also, Dr. Fenton's care is likely to expose other patients to harm or injury as well if it is conducted similarly to his care of Patient D.

In order to investigate this complaint, the College requested Dr. Fenton's medical records for Patient D on March 16, 2016. Subsequent requests from the College, including from the Chair of the ICRC, were sent to Dr. Fenton on April 28 and May 16, 2016. No records were received in response to these written requests. On July 13, 2016, the College's investigator contacted Dr. Fenton by telephone and requested that

he provide his medical records for Patient D. These records were ultimately received by the College on July 18, 2016.

Dr. Fenton is incompetent and failed to maintain the standard of practice in his care and treatment of Patient D, as described above. Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in his failure to respond to inquiries from the College within a reasonable time.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Fenton's certificate of registration for a period of six (6) months commencing on March 21, 2017, at 12:01 a.m.
- The Registrar impose the following terms, conditions and limitations on Dr. Fenton's certificate of registration:

Education

(a) Dr. Fenton shall, at his own expense, participate in and successfully complete the following educational courses within six (6) months of the date of this Order:

(i) the Medical Record Keeping Course offered through the University of Toronto;

(ii) the Pri-Med Canada Course (formerly Primary Care Today Course) scheduled for May 10-13, 2017;

(iii) the Understanding Boundaries Course offered through the University of Western Ontario;

(iv) individualized instruction in ethics, satisfactory to the College, with an instructor satisfactory to the College; and

(v) individualized instruction in communications, satisfactory to the College, with an instructor satisfactory to the College.

(b) Further to paragraphs 6(a)(iv) and 6(a)(v), the instructor(s) shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Fenton, including information regarding Dr. Fenton's progress and compliance.

Clinical Supervision

(c) Dr. Fenton shall, by September 21, 2017, retain a clinical supervisor or supervisors (the "Clinical Supervisor") acceptable to the College, who will sign an undertaking in the form attached hereto as Schedule "A". For a period of twelve (12) months thereafter, Dr. Fenton may practise only under the supervision of the Clinical Supervisor. Clinical Supervision of Dr. Fenton's practice shall contain the following elements:

(i) The Clinical Supervision shall be at a moderate level for a minimum of six (6) months, commencing on the date Dr. Fenton returns to work following the expiry of the suspension of his certificate of registration. The Clinical Supervisor will meet with Dr. Fenton weekly and review ten to fifteen (10-15) of Dr. Fenton's patient charts, discuss Dr. Fenton's patient care, treatment plan and follow-up, identify any

concerns regarding the care, treatment plan and follow-up and make recommendations for improvement;

(ii) Dr. Fenton shall permit the Clinical Supervisor to directly observe him in practice for one half-day per week or, at minimum, five (5) patients per visit, with the Clinical Supervisor providing a report every month to the College;

(iii) After three (3) months, and only upon recommendation by the Clinical Supervisor and approval of the College, the frequency of the meetings with and observation by the Clinical Supervisor may be reduced to biweekly;

(iv) After six (6) months of moderate level supervision, at minimum, and only upon recommendation by the Clinical Supervisor and approval of the College, the Clinical Supervision may be reduced to low level supervision for six (6) months. During the period of low level supervision, the frequency of the Clinical Supervisor' meetings with and, if required, observation of Dr. Fenton shall be reduced to monthly;

(v) Dr. Fenton shall fully cooperate with, and shall abide by any recommendations of his Clinical Supervisor, including but not limited to any recommended practice improvements and ongoing professional development;

(vi) If a Clinical Supervisor who has given an undertaking in the form attached at Schedule "A" to this Order is unwilling or unable to continue to fulfill its terms, Dr. Fenton shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time; and

(vii) If Dr. Fenton is unable to obtain a Clinical Supervisor in accordance with paragraph 6(c) or paragraph 6(c)(vi) of this Order, he shall cease practising medicine immediately until such time as he has done so, and the fact that he has ceased practising medicine will constitute a term, condition or limitation on his certificate of registration until that time.

Reassessment

(d) Approximately six (6) months after the completion of Clinical Supervision, Dr. Fenton shall undergo a reassessment of his practice by a College-appointed assessor (the "Assessor"). The assessment may include a review of Dr. Fenton's patient charts, direct observation, interviews with staff and/or patients, one or more interviews with Dr. Fenton, and/or a formalized evaluation. The results of the assessment shall be reported to the College after which Dr. Fenton shall abide by any recommendations made by the Assessor by which the College has requested Dr. Fenton to abide.

(e) Dr. Fenton shall consent to such sharing of information among the Assessor, the Clinical Supervisor, and the College as any of them deem necessary or desirable in order to fulfill their respective obligations and in order to monitor Dr. Fenton's compliance with this Order and with any terms, conditions or limitations on his certificate of registration.

Monitoring

(f) Dr. Fenton shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities, such as a medical director, at any location where he practises ("Chief(s) of Staff") 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.

(g) Dr. Fenton shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within five (5) days of this Order and shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

(h) Dr. Fenton shall cooperate with unannounced inspections of his Practice Location(s) and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

(i) Dr. Fenton shall consent to the College making enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22, as amended ("NMS"), and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order and any terms, conditions or limitations on Dr. Fenton's certificate of registration.

(j) Dr. Fenton shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Fenton appear before the panel to be reprimanded.
- Dr. Fenton pay costs to the College in the amount of $ 5,500.00 within thirty 30 days of the date this Order becomes final.

2. Dr. R. Kakar

Name:	Dr. Ravi Kakar
Practice:	Psychiatry
Practice Location:	Markham
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	December 12, 2016
Written Decision Date:	February 15, 2017

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Kakar is a psychiatrist who practised at a private office in Markham.

Patient A

In October 2012, Patient A complained that Dr. Kakar diagnosed her with gout arthritis and prescribed a medication, Allopurinol, to which she had a severe allergic reaction resulting in serious side effects.

Patient A had started seeing Dr. Kakar for psychiatric care in August 2010. Dr. Kakar diagnosed Patient A's mental health issues and chronic pain, and prescribed psychiatric medications. Dr. Kakar also requisitioned blood work.

In September 2010, Patient A attended for a follow-up appointment to discuss her psychiatric conditions. At this visit, Dr. Kakar observed that the blood work results showed elevated uric acid levels, diagnosed gout arthritis and prescribed Allopurinol. There was no emergency or urgency requiring that Dr. Kakar treat Patient A at that time.

Patient A filled the prescription for Alluporinol on a date in early October 2010 and developed side effects including a fever and cough, a generalized rash, and swelling of the mouth, lips and tongue. Her side effects worsened into severe pain, swelling of the feet, and an inability to walk. Patient A was admitted to hospital on in early November 2010, where she was diagnosed with a severe allergic reaction to the Allopurinol, Toxic Epidermal Necrolysis.

A College-retained expert opined that Dr. Kakar's care of Patient A failed to maintain the standard of practice and displayed a serious lack of knowledge and judgment as follows:

- Dr. Kakar's prescribing of Allopurinol for gout arthritis was outside of his scope of practice and inappropriate;
- Dr. Kakar inappropriately minimized the seriousness of Patient A's concerns after she experienced a reaction to Allopurinol;
- Dr. Kakar's records of his treatment of Patient A failed to maintain the standard as the vast majority were illegible; and
- Dr. Kakar's prescription of Allopurinol to Patient A seriously harmed her and put her at life-threatening risk.

A second College-retained expert opined that Dr. Kakar's failure to conduct an adequate clinical examination, prior to diagnosis and prescribing of Allopurinol, failed to maintain the standard of practice and that he demonstrated a lack of knowledge, skill and judgment.

Misleading College during investigation

In his January 15, 2013, response to Patient A's complaint, Dr. Kakar stated to the College that he prescribed Allopurinol for Patient A at an appointment in late October 2010. He also provided a copy of his chart for Patient A which indicated that there was a

discussion about Allopurinol on that date in late October 2010, and that Dr. Kakar prescribed the medication on that day.

Subsequently, after the College provided Dr. Kakar with information indicating that the complainant had filled the prescription in early October, Dr. Kakar claimed that he relied on his chart when he responded to the complaint, and since the reference to the discussion about Allopurinol was recorded in the chart for the appointment in late October, he had presumed that was when he prescribed the medication. He said it must have been a late entry from October of 2010 which he had failed to indicate as such.

Then, in May of 2013, Dr. Kakar's counsel wrote to the College and admitted that Dr. Kakar had added the note in Patient A's chart about Allopurinol after he received the comlaint from patient A, in October 2012, not in October of 2010, as he had claimed in his communication to the College.

Patient B

In January 2013, the College received a complaint about the psychiatric care provided by Dr. Kakar to a teenage girl, Patient B, in the fall of 2012.
A College-retained expert concluded that Dr. Kakar failed to meet the standard of care in his record-keeping for Patient B as follows:

- Dr. Kakar's original office notes are illegible and needed to be transcribed in order for her to read them;
- Two of Dr. Kakar's progress notes, dated August 2012 and September 2012, were identical. This failed to reflect the true progression, or lack of progression, of Patient B's response to treatment; and
- Dr. Kakar's failure to document a rationale in his progress note of September 2012, for increasing the patient's dosage of Cymbalta to 30 mg three times a day.

It was also determined that Dr. Kakar made an error in his September 29, 2012 entry in Patient B's chart when he recorded a prescription for Cymbalta three times a day (t.i.d.), when he actually intended to prescribe it two times a day (b.i.d.), as written on the prescription.

Section 75.1(A) Investigation

A College-retained expert reviewed Dr. Kakar's care and treatment of 24 patients in his psychiatric practice and noted the following about his record-keeping:

- Dr. Kakar's charts have insufficient documentation of the progress of his patients;
- Dr. Kakar's charts fail to adequately identify the rationale for treatment modalities;
- Dr. Kakar's charts fail to adequately document follow up with patients suffering from mood disorders regarding risk of self-harm or cognitive deficits; and

- Dr. Kakar's medical reports lack contemporaneous information, are often repetitive in nature and sometimes contain information seen in the charts of other patients.

The expert opined that Dr. Kakar showed sufficient knowledge, skills and judgment in the clinical practice of psychiatry to meet the standards of the profession. However, while he appeared to have sufficient knowledge and judgment regarding information which should be documented in charts, his documentation did not meet the standard of practice.

The Dr. D. Complaint

In August 2015, Dr. D, a psychologist, complained to the College regarding a psychiatric report Dr. Kakar prepared on behalf of Patient C, an insured woman who sustained injuries in a car accident. Dr. D examined Patient C in November 2013 and completed a psychological report dated December 2013. Dr. Kakar saw the same patient later in December 2013, and produced a psychiatric report in January 2014.

In May 2015, Dr. D was asked to do a follow up report, and reviewed Patient C's file in order to do so. In the file, he found the report of Dr. Kakar in relation to Patient C, which contained extensive sections that were copied from Dr. D's initial report, with virtually no changes.

Dr. Kakar said that when he was asked to provide a report, he reviewed the medical brief, which included Dr. D's report, in preparation for his independent psychiatric evaluation of the patient. He said he used Dr. D's report as a guide to his interview and as a means of obtaining an accurate and detailed history from the patient.

<u>Agreed Facts on Penalty</u>

In May 2006, the Complaints Committee issued a verbal caution regarding Dr. Kakar's care of a patient, and in particular, regarding the preparation of third party reports regarding the patient's mental state and ability to care for his child. In June of 2009, following a public complaint and investigation regarding his standard of practice, Dr. Kakar entered into an undertaking with the College which required among other things, that he practise under the guidance of a clinical supervisor; complete courses in pharmacological monitoring, assessment of suicide, communication skills and record keeping; and attend psychiatric rounds every two months for one year.

During 2012 and 2013, Dr. Kakar experienced a series of stressors which impacted his health. Ultimately, he signed an undertaking to cease practice medicine which was in effect between February 2014 and January 2015.

Pursuant to an October 23, 2013 undertaking, which he executed after receiving the complaint of Patient A Dr. Kakar has publicly restricted his practice to that of psychiatry only.

Pursuant to a February 10, 2016 undertaking, which he executed in lieu of a s. 37 Order, Dr. Kakar has been practising under supervision since this matter was referred to discipline.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Kakar's certificate of registration for a period of six (6) months commencing January 1, 2017.
- The Registrar impose the following terms, conditions and limitations on Dr. Kakar's certificate of registration:
    - Dr. Kakar's practice shall be restricted to psychiatry only.
    - Dr. Kakar shall not see more than 18 patients in any 24-hour period. Dr. Kakar will also maintain a log of all patient encounters in the form attached to this Order as Appendix "A" (the "Patient Log") and will submit the Patient Log to the College on a monthly basis until the reassessment referred to in paragraph 6(vi) below has been completed, and the results of the reassessment have been considered by the ICR Committee. Thereafter, Dr. Kakar shall produce the Patient Log at any time upon request of the College.
    - Dr. Kakar shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor"), who will sign an undertaking in the form attached hereto as Appendix "B." For a period of at least twelve (12) months commencing on the date Dr. Kakar returns to practice following the suspension of his certificate of registration, Dr. Kakar may practise only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management, third party report writing, and continuing education. Clinical supervision of Dr. Kakar's practice may end after a minimum of twelve (12) months, only upon the recommendation of the Clinical Supervisor and, in its discretion, approval by the College. Clinical supervision of Dr. Kakar's practice shall contain the following elements:
        - Dr. Kakar shall facilitate review by the Clinical Supervisor of fifteen (15) patient charts per month and will meet with the Clinical Supervisor at least once a month to discuss his care of patients; and
        - Dr. Kakar will have all third party reports as defined in the College Policy Third Party Reports, a copy of which is attached as Appendix "C" to this Order, reviewed and approved by the Clinical Supervisor before they are provided to the third party. Before Dr. Kakar provides the report to the party requesting it, he must ensure the Clinical Supervisor has approved and has indicated such approval by personally affixing his/her signature on the report. Dr. Kakar will also maintain a log with the name of each patient for whom a third

party report is requested, the date he saw the patient, the date the report was sent to the Clinical Supervisor for approval, the date it was approved by the Clinical Supervisor, and the date it was sent to the third party, in the form attached to this Order as Appendix "D" (the "Third Party Report Log"). Dr. Kakar will provide the Third Party Report Log to the Clinical Supervisor each time they meet. He will also provide the original Third Party Log to the College upon request. This restriction will remain in place until the reassessment referred to in paragraph 6(vi) below has been completed, and the results of the Reassessment have been considered by the ICR Committee.

- Dr. Kakar shall successfully complete and provide proof thereof to the College within six (6) months of the date of the Order:
    - Education in ethics acceptable to the College; and
    - Education in third party report writing acceptable to the College.
- If Dr. Kakar fails to retain a Clinical Supervisor as required above or if, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Kakar shall within twenty (20) days retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Appendix "B," and shall cease to practise until the same has been delivered to the College.
- Approximately nine (9) months after the completion of Clinical Supervision, Dr. Kakar shall undergo a reassessment of his practice (the "Reassessment") by a College-appointed assessor (the "Assessor"). The Reassessment may include a review of Dr. Kakar's patient charts, direct observations and interviews with staff and/or patients, and any other tools deemed necessary by the College. The Reassessment shall be at Dr. Kakar's expense and he shall co-operate with all elements of the Reassessment. Dr. Kakar shall abide by all recommendations made by the Assessor subject to paragraph 6(vii) below, and the results of the Reassessment will be reported to the College and may form the basis of further action by the College.
- If Dr. Kakar is of the view that any of the Assessor's recommendations are unreasonable, he will have fifteen (15) days following his receipt of the recommendations within which to provide the College with his submissions in this regard. The Inquiries Complaints and Reports ("ICR") Committee will consider those submissions and make a determination regarding whether the recommendations are reasonable, and that decision will be provided to Dr. Kakar. Following that decision Dr. Kakar will abide by those recommendations of the Assessor that the ICR Committee has determined are reasonable
- Dr. Kakar shall consent to sharing of information among the Assessor, the Clinical Supervisor, the College, and any education providers under paragraph 6(iv) above as any of them deem necessary or desirable in order to fulfill their respective obligations.

- Dr. Kakar shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Kakar shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Kakar shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
- Dr. Kakar shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Kakar shall comply with the College's Policy on Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation, in respect of his period of suspension, a copy of which is attached hereto as Appendix "E".

- Dr. Kakar attend before the panel to be reprimanded.
- Dr. Kakar pay to the College costs in the amount of $5,000.00, within thirty (30) days of the date of this Order.

3. Dr. S. L. Roche

Name:	Dr. Susan Louise Roche
Practice:	Psychiatry
Practice Location:	Ottawa
Hearing:	Uncontested Facts and Joint Submission on Penalty
Decision Date:	March 13, 2017
Written Decision Date:	March 28, 2017

Allegations and Findings

- Incompetence – **proved**
- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Roche is a psychiatrist who received her certificate of registration authorizing independent practice in Ontario on June 28, 1989. At the relevant time, Dr. Roche practised in Ottawa.

Disgraceful, Dishonourable and Unprofessional Conduct re Patient A

Patient A was a registered nurse who retired in or around October 2013 and was Dr. Roche's patient for over 20 years. Dr. Roche treated her for clinical depression, weekly for individual therapy as well as weekly for group therapy.

In or around the summer of 2014, in the course of their private therapy, Dr. Roche asked Patient A if she would be interested in moving to British Columbia with her and being her tenant in a home she planned to buy there. All subsequent planning discussions took place during individual planning sessions. A couple months later, Dr. Roche hired Patient A in her professional capacity as a registered nurse to care for her during her recovery from abdominal surgery. Dr. Roche offered to pay Patient A $500 for nursing care for a one week period as well as gas money for travel to and from the Hospital and to post-operative appointments. Patient A stayed in Dr. Roche's home following her surgery, to care for Dr. Roche for seven days in November 2014. While caring for in her home, Dr. Roche was agitated and difficult. She shouted at Patient A and used foul language and told Patient A that she was dissatisfied with her services.

Patient A attended in January 2015 at Dr. Roche's office for their next scheduled therapy session. At that appointment, Dr. Roche became upset with her and told her she had changed her mind about moving to B.C. Also, Dr. Roche complained about her nursing services and stated that she decided not to pay her any more money for the services she provided. Patient A attended a subsequent appointment in February in which Dr. Roche continued to be verbally aggressive. Patient A did not book a further appointment for individual therapy.

Following the February 2015 appointment, Dr. Roche left Patient A a voicemail advising her not to attend group therapy until she attended further individual therapy. Patient A learned later that Dr. Roche had advised the group that Patient A was absent because she had "regressed" and there was a parking issue. Patient A did not give Dr. Roche consent to discuss her departure from group therapy with the others.

Patient A terminated the doctor-patient relationship by sending Dr. Roche a registered letter of termination. Dr. Roche refused to accept delivery, and did not transfer her patient files until at least seven weeks after receiving a signed consent.

Disgraceful, Dishonourable and Unprofessional Conduct in respect of Other Patients

Dr. Roche requested other patients to do errands for her. Specifically, she asked a patient to retrieve her eye medication, and another patient frequently picked up groceries for her.

Failed to Maintain the Standard of Practice of the Profession and is Incompetent

The College retained a psychiatrist who opined with respect to Dr. Roche's care and treatment of Patient A that:

- In hiring a patient she had worked with extensively, Dr. Roche did not meet the standard of practice as a physician. In not considering the aforementioned ways this could have affect the psychotherapeutic relationship, it also demonstrated a lack of skill and judgment as a therapist. The risks of the employment relationship should have been easily foreseeable to Dr. Roche. In this case, it caused harm to the patient in that it led to the termination of what had been a 20 year long therapeutic relationship.
- Dr. Roche stated that there "is no pressure" for Ms. C. to accept her offer to be her nurse. As an experienced therapist, the expected standard would be for Dr. Roche to recognize that there is an inherent pressure which cannot be eliminated by attempting to convince the patient otherwise.
- The offer of tenancy would be below the standard. If it had ultimately been entered into, the risk of harm, would be the same as what the employment situation led to, namely tension in the relationship and an ultimate severing.
- Asking patients to perform errands for her would be taking advantage of a therapist patient relationship for personal gain and would be considered unprofessional and below the standard of care. If somehow Dr. Roche did not consider these patient performing errands as transgressions, then at best she would be showing poor judgment for not recognizing them as such.
- It is uncommon for a therapist to provide both individual psychotherapy and group psychotherapy for the same patient, though it does occur. In this scenario, there is a requirement for confidentiality around the material discussed during the patient's individual therapy. Sharing information about co-patients during individual sessions and sharing information about one patient during a group session would constitute breaches of confidentiality contrary to the CPSO policy. As such, Dr. Roche falls below the standard of care.
- Dr. Roche was inappropriately billing for family therapy instead of individual or group therapy. There is a financial advantage to coding therapy sessions as family therapy.
- Dr. Roche's documentation failed to maintain the standard of practice of the profession. There is little mention of the particular symptoms of major depressive disorder for which the patient was receiving treatment. It was difficult to ascertain the patient's clinical status of any given time which is essential. There was no suicide risk assessment.

The psychiatric expert concluded that the most notable demonstrations of falling below the standard of care related to the lack of boundaries between Dr. Roche and certain patients.

The College retained a second psychiatric expert opinion who, like the first expert, opined that Dr. Roche did not meet the standard of practice and showed a lack of knowledge skill and judgment with respect to observing appropriate boundaries with her patient. The second expert also found Dr. Roche breached the standard of care by billing her individual sessions with Patient A as family sessions, at a higher rate than she was entitled.

Dr. Roche signed an Undertaking, Acknowledgment and Consent on February 17, 2017, in which she resigned from the College effective March 10, 2017 and agreed not to apply or re-apply for registration as a physician in the province of Ontario or any other jurisdiction after that date.

Disposition

As Dr. Roche had signed an undertaking to resign and not to reapply, the Discipline Committee ordered and directed that:

- Dr. Roche appear before the panel to be reprimanded.
- Dr. Roche pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order becomes final.

Failed to maintain the standard of practice - 4 cases

1. Dr. T.J. Barnard

Name:	Dr. Thomas Joseph Barnard
Practice:	Family Medicine
Practice Location:	Windsor
Hearing:	Agreed Facts and Uncontested Facts and Joint Submission on Penalty
Decision Date:	February 13, 2017
Written Decision Date:	March 28, 2017

Allegations and Findings

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence - **withdrawn**

Summary

Dr. Barnard is a family physician practising in Windsor. He operates a family medicine practice called the Barnard Wellness Centre, at which he is the sole primary care physician, and also operates the Fresh Medical Spa, which is located at the same address as his family medicine practice.

Failed to Maintain the Standard of Practice

Section 75(1)(a) Investigation into care of a single patient

On October 18, 2012, the College received a letter from the Chief Coroner for Ontario, enclosing reports from a Coroner's investigation of the death of a person who was a regular patient of Dr. Barnard's between May 2000 and April 2012. The Coroner's report indicated that the cause of death was a multi-drug toxicity, which included controlled substances that had been prescribed to the patient by Dr. Barnard.
Dr. Barnard failed to maintain the standard of practice of the profession in his care and treatment of the patient.

The College retained a family physician who found that Dr. Barnard demonstrated a lack of skill and did not meet the standard of practice for the following reasons:

- His information gathering was perfunctory;
- His histories were not sufficiently detailed;
- The physical examinations were cursory at best and appeared to be generated from a template. Often they were not relevant to the presenting complaint;

- There was no information about family history in his notes. It was gathered from the consultant reports;
- The patient's surgical history was not recorded except in the consultant's notes;
- He did not routinely ask about allergies;
- His assessments were not based on the history and physical findings; he often reiterated the patient's complaint rather than making a true diagnosis;
- The rationale for his treatment plans was difficult to understand;
- The Cumulative Patient Profile ("CPP") at the front of the chart was difficult to read;
- The results of the patient's tests were not organized for easy retrieval; and
- He did not keep an up to date list of the medications that were prescribed and every consultant who looked after the patient had an incomplete or inaccurate list of her actual medications.

The family physician also opined that Dr. Barnard: lacked knowledge about the risks of polypharmacy and the risks of treating chronic pain with opioid analgesics; demonstrated a lack of judgment by continuing to prescribe drug combinations with known risks of harm, by continuing to prescribe narcotics when it was obvious that the patient was unable to control her use and the medication was doing more 'to her' than 'for her', and by continuing to provide the patient with large numbers of narcotics when he knew the patient was unable to prevent theft by her husband.

On November 9, 2014, Dr. Barnard signed an undertaking to the College restricting him from prescribing any Narcotics, Controlled Drugs, Benzodiazepines/Other Targeted Substances and all other Monitored Drugs and Narcotics Preparations, with the exception of Tylenol with codeine #3 in limited amounts.

Section 75(1)(a) Investigation into prescribing practices

The College conducted a broader investigation into Dr. Barnard's prescribing practices with respect to 25 patients. A family physician retained by the College concluded that Dr. Barnard's care of 11 patients did not meet the standard of practice and that he demonstrated various degrees of a lack of knowledge, skill or judgment. He opined that in 7 charts the care provided posed a potential risk of exposing patients to harm or injury and, of these 7, the risk of harm was particularly high with respect to 4 patients. The four cases in which it was concluded that the risk of exposing the patient to harm or injury was particularly high were those in which:

- A patient was receiving frequent morphine injections as well as other narcotics while she was pregnant;
- A patient who had severe migraine headaches was receiving frequent morphine injections as well as nasal butorphanol, the amounts of which were well in excess of recommended guidelines for non-cancer pain;
- A patient was receiving very frequent morphine injections for chronic pelvic pain, much in excess of recommended guidelines; and
- A patient's chart contained indications from anonymous phone calls that he was selling his medication and a letter from the Children's Aid Society expressing

concern of large amounts of narcotic medication in a household with small children.

Dr. Barnard failed to maintain the standard of practice of the profession in his care of 11 patients.

Section 75(1)(a) Investigation regarding broader patient care

On September 18, 2012, the College received information regarding Dr. Barnard from the Ministry of Health and Long-Term Care (MOHLTC) as a result of a review of his medical records for services completed in 2009. MOHLTC medical advisors identified clinical concerns with respect to Dr. Barnard's patient care.

The College retained a family physician to provide an opinion regarding the standard of care provided by Dr. Barnard to 37 patients. The family physician concluded that the standard of care was not met in any of the cases reviewed and that Dr. Barnard displayed a lack of knowledge and judgment in each case. She also opined that Dr. Barnard's clinical practice and conduct exposed all but one of the patients whose care was reviewed to a risk of harm. The conclusions were based, in part, on the following concerns:

- Dr. Barnard's administration of human chorionic gonadotropin ("HCG," known colloquially as "human growth hormone") for weight loss in the management of obesity despite it being discredited and rejected by the medical community;
- Numerous, significant examples of disjointed and episodic care with poor recordkeeping and judgment that impairs the provision of an adequate diagnosis and case management;
- Certain use of "off label" prescribing and potentially harmful prescribing (including prescribing HCG as described above; potentially harmful prescribing of narcotics for non-cancer pain; prescribing benzodiazepines with narcotics; Methotrexate and Plaquenil without indication; prescribing hormone replacement therapy without appropriate documentation and assessment; prescribing high doses of vitamin D; prescribing iron and high doses of vitamin B without indication);
- Failure to meet the standard in his documentation of consent for "off label" or potentially harmful prescribing, and other failures of documentation;
- Lack of documentation of appropriate follow-up on test results;
- Failing to document history, physical examination, diagnosis, and informed consent when prescribing complementary and alternative medicines, and prescribing some such medicines which he knew had no medical evidence for use, such as HCG; and
- The use of excessive laboratory testing in the absence of clear documentation of medical need.

In December 2015, the College requested updated patient records from Dr. Barnard for 10 patients whose care had been reviewed. It was found that Dr. Barnard's care did not meet the standard of practice in any of the charts reviewed and that his care continued to display a lack of knowledge, skill and judgment.
Dr. Barnard failed to maintain the standard of practice of the profession in his care of 37 patients as described above.

Investigation Regarding Patient A

Patient A became Dr. Barnard's patient in the Barnard Wellness Centre in May 2012. Patient A had a history of testosterone levels having been documented as low by other physicians as recently as 2011, but it was very high based on the initial bloodwork ordered by Dr. Barnard in May 2012.

Dr. Barnard treated Patient A, including continually prescribing testosterone injections from July 2012 until April 2013, when Dr. Barnard severed the doctor-patient relationship.

The College retained a family physician with a focus in men's health, including testosterone deficiency, to review Dr. Barnard's care in regard to Patient A, who found that Dr. Barnard did not meet the standard of practice of the profession in that he:

- Displayed poor documentation and recordkeeping of his thought process and/or discussions with Patient A;
- Failed to adequately counsel Patient A in the hazards of continued steroid use;
- failed to try to have Patient A adhere to a more traditional protocol for testosterone replacement, with lower initial dosing and further titration based on serum testosterone levels and/or symptom management, and escalated the dosage of testosterone without monitoring hematocrit; and
- Demonstrated poor judgment in embarking on an unorthodox treatment plan of high dosing with little monitoring that, while for the most part it worked along with the desires and with the consent of the patient, was not in the best long term interests of the patient.

Dr. Barnard failed to maintain the standard of practice of the profession in his care of Patient A.

Investigation Regarding Patients B and C

Patient B became Dr. Barnard's patient in March 2012 and Patient C became Dr. Barnard's patient in February. Dr. Barnard terminated both patients from his practice.
Dr. Barnard treated Patient B for chronic pain. He prescribed Lyrica, Cymbalta, Botox injections, vitamin injections and testosterone injections beginning in May 2012. Dr. Barnard did not record Patient B's serum testosterone levels before prescribing testosterone injections.

The College retained a family physician to review the care provided by Dr. Barnard to Patients B and C, who opined that the care provided to both patients fell below the standard of the profession based on a lack of skill, knowledge and judgement and that

Dr. Barnard's care exposed them to harm. Specifically, Dr. Barnard:

- Demonstrated a lack of skill in the quality and quantity of his information gathering, in his record keeping and in his performance of proper physical assessments;
- Demonstrated a lack of knowledge when he increased Patient C's dose of thyroxine and added Cytomel without evidence of thyroid deficiency;
- Demonstrated a lack of knowledge when he prescribed Flagyl to Patient C without indication;
- Demonstrated a lack of knowledge in failing to identify the significance of Patient C's rising erythrocyte sedimentation rate ("ESR") (which with other symptoms was suggestive of an autoimmune disorder); and
- Demonstrated poor judgment in failing to comply with College guidelines for record keeping, prescribing drugs and the use of alternative therapies.

The College retained a second family physician with some knowledge of and interest in complementary and alternative medicine, to provide an opinion regarding Dr. Barnard's care of Patients B and C, having regard to the College's Complementary/Alternative Medicine Policy. With regard to Patient B, the family physician opined that Dr. Barnard's use of testosterone and vitamin injections was unconventional and not supported by any scientific evidence of which he was aware. Dr. Barnard had failed to clearly indicate the diagnosis although he treated chronic pain syndrome with an associated neuropathy.

Dr. Barnard did not document valid informed consent for his unconventional therapeutic interventions.

With respect to Patient C:

- Dr. Barnard's care of Patient C's inflammatory disorders falls within the realm of complementary medicine;
- Dr. Barnard failed to provide an appropriate clinical assessment with regard to Patient C. He recorded no clear working diagnosis or treatment plan;
- Dr. Barnard failed to document a conventional diagnosis;
- He did not record any evidence of informed consent having been obtained for the unconventional therapeutic interventions;
- He failed to address the patient's elevated ESR; and
- Despite the poor assessment and review of Patient C, his care did not demonstrate a lack of knowledge or skills. However, Dr. Barnard showed poor judgment by failing to document more appropriate patient counselling regarding the unconventional therapies being utilized.

Dr. Barnard failed to maintain the standard of practice of the profession in his care of Patients B and C.

Investigations Regarding Patients D, E and F

Patients D, E and F, who were a mother and her two children, became Dr. Barnard's patients in the Fall/Winter of 2010/2011, and continued as his patients until November 2013.

The College retained a family physician to review the standard of care provided by Dr. Barnard to Patients D, E and F, who concluded that Dr. Barnard did not meet the standard of practice of the profession in relation to Patients D, E and F and that he demonstrated a lack of knowledge and skill. Examples of Dr. Barnard's lack of knowledge and skill include:

- a lack of knowledge of appropriate testing and investigations for specific symptoms. Among other things, Dr. Barnard repeatedly ordered a broad spectrum of tests on Patients D, E and F without indication, including broad annual testing for Patient D, and ordered specific tests that were not inappropriate based on the patient's age or lack of suitability as a screening tool;
- a lack of knowledge in treating asthma in children with respect to Patients E and F, where those patients received oral medications without any clear indication for their use and without corresponding use of inhaled medications;
- a lack of knowledge in the use of antibiotics, including prescribing incorrect doses and prescribing in cases where antibiotics are not indicated;
- a lack of knowledge in prescribing with respect to dosage of Topamax;
- a lack of knowledge of the treatment of anxiety for Patient D, and giving inappropriate treatment for the same; and
- a lack of skill in the documentation of visits, including incomplete or absent charting of history, physical examinations and assessments that seemed to be in an identical template for nearly every visit, missing vital signs, and a lack of any differential diagnosis and treatment plan in any of the entries.

Dr. Barnard failed to maintain the standard of practice of the profession in his care of Patients D, E. and F.

<u>Disgraceful, Dishonourable and Unprofessional Conduct</u>

Patient B became Dr. Barnard's patient in 2012 and his wife, Patient C, became Dr. Barnard's patient in 2013. During a double appointment in 2013, attended by both Patient B and C, Dr. Barnard became upset when asked to complete a Functional Abilities Form for Patient B. He told Patient B to "come back when you have your head screwed on right". Patient B and C left the office. A few days later, they received a letter from Dr. Barnard sent by courier terminating both patients from his practice. The letter and termination were unexpected. Prior to the termination, Dr. Barnard had requested a consultation with a specialist for Patient C. Shortly after the last appointment, and before receiving the termination letter, Patient C received a call from Dr. Barnard's office indicating the date and time for the specialist consultation. On the scheduled date in July, Patient B and Patient C attended at the specialist's office for the consultation.

However, when they arrived they were told that although Patient C had been booked for an appointment, it had been cancelled. Dr. Barnard did not advise Patient C at any time that he had cancelled her consultation with the specialist.

Dr. Barnard engaged in disgraceful, dishonourable and unprofessional conduct in the manner in which he terminated Patients B and C from his practice, in cancelling Patient C's specialist consultation and in failing to notify her of the cancellation.
Dr. Barnard entered into an undertaking to the College on January 20, 2017, by which he has agreed, among other things, that, effective March 17, 2017, he shall no longer practice family medicine and shall no longer bill the Ontario Health Insurance Plan. Dr. Barnard may only provide certain aesthetic and cosmetic services and may provide nutritional counselling. Dr. Barnard shall post a clearly visible sign in the waiting rooms of all his Practice Locations, which states as follows: "Dr. Barnard must not practise family medicine or provide any OHIP-insured service."

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Barnard's certificate of registration for a period of four (4) months commencing on March 17, 2017 at 12:01 a.m.
- The Registrar impose the following terms, conditions and limitations on Dr. Barnard's certificate of registration:
    a. Dr. Barnard shall not prescribe or recommend human chorionic gonadotropin ("HCG") for the purpose of weight loss to any individual;
    b. Dr. Barnard shall have clinical interactions with no more than a total of forty-eight (48) patients per day, at a rate of no more than six (6) patients per hour within each hour;
    c. Dr. Barnard shall execute the Prescribing Resignation Letter to Health Canada, which is attached hereto as Schedule "A" (the "Resignation Letter") to the Order, and shall consent to the College sending the Resignation Letter to Health Canada on his behalf;
    d. Dr. Barnard shall not issue new prescriptions or renew existing prescriptions 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);

    (A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule "B" to the Order; and the current regulatory lists are attached hereto as Schedule "C" to the Order)

v. All other Monitored Drugs (as defined under the *Narcotics Safety* and *Awareness Act, 2010*, S.O. 2010, c. 22 as noted in Schedule "D" to the Order);

and as amended from time to time.

e. Dr. Barnard shall, by July 17, 2017, retain a clinical supervisor or supervisors (the "Clinical Supervisor") acceptable to the College, who will sign an undertaking in the form attached hereto as Schedule "E" to the Order. For a period of four (4) months thereafter, Dr. Barnard may practise only under the supervision of the Clinical Supervisor. Clinical supervision of Dr. Barnard's practice shall contain the following elements:
   i. Dr. Barnard shall facilitate review by the Clinical Supervisor of twenty (20) patient charts per month or, should Dr. Barnard treat fewer than twenty (20) patients in any month, the charts of all patients with whom he had clinical interactions in that month, and shall permit the Clinical Supervisor to directly observe him in practice for one half-day per month, with the Clinical Supervisor providing a report every two (2) months to the College.
   ii. Dr. Barnard shall meet with the Clinical Supervisor at least once per month or more frequently if requested by the Clinical Supervisor, to: discuss the results of the Clinical Supervisor's review of patient charts and direct observation of Dr. Barnard's practice; discuss Dr. Barnard's care, treatment plans, and follow-up; identify any issues or concerns regarding Dr. Barnard 's care, treatment plans, or follow-up, discuss and receive recommendations for improvement and professional development.
   iii. Dr. Barnard shall fully cooperate with, and shall abide by any recommendations of, his Clinical Supervisor, including but not limited to any recommended practice improvements and ongoing professional development.
   iv. If a Clinical Supervisor who has given an undertaking in the form attached at Schedule "E" to this Order is unwilling or unable to continue to fulfill its terms, Dr. Barnard shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.
   v. If Dr. Barnard is unable to obtain a Clinical Supervisor in accordance with paragraph 5(v) or paragraph 5(v)(d) of this Order, he shall cease practising medicine immediately until such time as he has done so, and the fact that he has ceased practising medicine will constitute a term, condition or limitation on his certificate of registration until that time.
f. Approximately six (6) months after the completion of Clinical Supervision, Dr. Barnard shall undergo a reassessment of his practice by a College-appointed assessor (the "Assessor"). The assessment may include a review of Dr. Barnard's patient charts, direct observation, interviews with staff and/or patients, one or more interviews with Dr. Barnard, and/or a formalized

evaluation. The results of the assessment shall be reported to the College after which Dr. Barnard shall abide by any recommendations made by the Assessor by which the College has requested Dr. Barnard to abide.

g. Dr. Barnard shall consent to such sharing of information among the Assessor, the Clinical Supervisor, and the College as any of them deem necessary or desirable in order to fulfill their respective obligations and in order to monitor Dr. Barnard's compliance with this Order and with any terms, conditions or limitations on his certificate of registration.
h. Dr. Barnard shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities, such as a medical director, at any location where he practises ("Chief(s) of Staff") 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.
i. Dr. Barnard shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within five (5) days of this Order and shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.
j. Dr. Barnard shall maintain an up-to-date daily log of every patient with whom he has a clinical interaction, which shall include the patient's name, the date, and the hour within which the clinical interaction occurred ("Patient Log"). Dr. Barnard shall maintain the original Patient Log and shall send a copy to the College at the end of every calendar month.
k. Dr. Barnard shall cooperate with unannounced inspections of his Practice Location(s) and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
l. Dr. Barnard shall post a sign in the waiting room(s) of all his Practice Locations, in a clearly visible and secure location, in the form set out at Schedule "F" to the Order, and a certified translation of the same in any language in which he provides services, with Dr. Barnard providing such certified translation to the College within thirty (30) days of this Order or, should he later begin providing services in another language, prior to doing so. For further clarity, this sign shall state as follows:

IMPORTANT NOTICE

Dr. Barnard must not prescribe:
- Narcotic Drugs
- Narcotic Preparations
- Controlled Drugs
- Benzodiazepines or 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

m. Dr. Barnard shall consent to the College making enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22, as amended ("NMS"), and/or any person who or institution that may have relevant information, in order for the

College to monitor and enforce his compliance with the terms of this Order and any terms, conditions or limitations on Dr. Barnard's certificate of registration.

n. Dr. Barnard shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Barnard attend before the panel to be reprimanded.
- Dr. Barnard pay to the College costs in the amount of $5,000.00, within thirty (30) days of the date of this Order.

2. Dr. W.A. Botros

Name:	Dr. Wagdy Abdalla Botros
Practice:	Psychiatry, Sleep Medicine
Practice Location:	formerly Kitchener
Hearing:	Contested
Finding / Written Decision Date:	March 7, 2016
Penalty Decision Date:	September 23, 2016
Penalty Written Decision Date:	February 15, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **not pursued**

Summary

The Discipline Committee found that Dr. Botros failed to maintain the standard in relation to leaving one patient's Obstructive Sleep Apnea untreated and failing to attempt to assist a second patient when an emergency arose when her CPAP machine broke. The Committee also found that Dr. Botros engaged in disgraceful, dishonourable, or unprofessional conduct in relation to his delay in providing records to and in his manner of communication with the X Law Firm.

Disposition

The Discipline Committee ordered and directed that:

- Dr. Botros appear before the Panel to be reprimanded;
- The Registrar suspend Dr. Botros' certificate of registration for a period of four (4) months commencing immediately, to run concurrently with respect to any unexpired portion of the suspension imposed by the Discipline Committee in its decision of February 22, 2016;
- At his own expense, Dr. Botros 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 provided 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. Botros;
- Dr. Botros shall, within three months, pay a fine to the Minister of Finance in the amount of $20,000.00, and that Dr. Botros shall provide proof of this payment to the Registrar of the College.
- Dr. Botros pay costs to the College in the amount of $17,840.00 within 60 days of the date of this Order.

3. Dr. B. Pardis

Name:	Dr. Bijan Pardis
Practice:	Family Medicine
Practice Location:	Markham
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	March 8, 2017
Written Decision Date:	May 2, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Incompetence – **withdrawn**

Summary

Dr. Pardis is a family physician who practised in the Greater Toronto Area, maintaining both a family practice and a methadone practice.

Family Practice

In February 2013, the Inquiries, Complaints and Reports Committee of the College required Dr. Pardis to complete a specified education and remediation program directed at his family practice, including coursework, a preceptorship, and a reassessment. The preceptor identified a number of concerns with Dr. Pardis' practice, including a need for better documentation of physician-patient encounters and to consistently update Cumulative Patient Profiles. The preceptor found that Dr. Pardis made improvements in his recordkeeping throughout the course of the preceptorship, however, identified a number of specific care concerns, including two cases in which symptoms that Dr. Pardis failed to investigate could be due to an underlying malignancy. As a result, the College commenced an investigation into Dr. Pardis' practice.

The medical expert who reviewed Dr. Pardis' family practice observed that Dr. Pardis' practice consisted primarily of immigrants from Iran, many of whom spent time regularly in Iran while also seeing physicians there, and that it was difficult to provide comprehensive coordinated care to those patients. He indicated that Dr. Pardis provided care with cultural sensitivity and demonstrated knowledge of the

circumstances of their lives. However, Dr. Pardis failed to meet the standard of practice of the profession. His recordkeeping fell below the standard in most cases. He failed to provide preventive care that met the standard of practice in the majority of cases. He lacked a coordinated approach to chronic disease management. He did not document; weighing the risks when prescribing non-steroidal anti-inflammatory drugs ("NSAIDs") to patients with cardiovascular risk factors and/or gastrointestinal inflammation and lacked knowledge in this regard. He did not take steps to provide renal and vascular protection to patients with diabetes. He engaged in over-testing and over-screening, including by ordering unnecessary echocardiograms and routine blood and urine testing without justification. He overprescribed antibiotics for viral illnesses. He co-ordinated care poorly with consultants regarding medication management.

The medical expert found a more immediate risk of harm in four cases, and found that on balance that Dr. Pardis' care was "substandard" and represented a potential risk of harm.

Methadone Practice

As a result of clinical concerns on the part of the College's Methadone Committee regarding Dr. Pardis' methadone practice and his ongoing deviations from the Methadone Maintenance Treatment Guidelines, Dr. Pardis entered into an undertaking on November 9, 2010, by which he agreed that his methadone practice would be subject to clinical supervision and would be reassessed by a College-appointed assessor.

The assessor found that Dr. Pardis failed to meet the standard of practice of the profession regarding three patients, and in his medical record-keeping, which was so deficient that it was not possible to determine in other cases whether his care met the standard of practice of the profession. The assessor also noted concerns regarding Dr. Pardis' prescribing of testosterone replacement to methadone patients, specifically appropriate dosage and regular monitoring of the same in eight cases.

In response to the assessor's concerns, Dr. Pardis indicated that he had made changes to his practice, including only prescribing medications in his methadone practice that are related to methadone treatment and its side effects, seeking to improve his counselling of patients about side effects and risks of medications and documenting those discussions, and documenting patient counselling. He also advised that he had upgraded his electronic medical recordkeeping system to include a methadone module.

College History

In February 2013, the Inquiries, Complaints and Reports Committee ("ICRC") of the College considered a report of an investigation into Dr. Pardis' family practice, which noted deficiencies of care, including in primary prevention. The ICRC ordered Dr. Pardis to undergo a specified continuing education or remediation program ("SCERP"), which resulted in the preceptorship described above. The ICRC also issued Dr. Pardis a

written caution with respect to his record-keeping, which it described as “very deficient,” and provided him with advice about his practice management.

Also in February 2013, the ICRC issued in a public complaint a written caution to Dr. Pardis with respect to compliance with the College policy on *Ending the Physician-Patient Relationship* and also practice deficiencies that result in poor patient care, including that: he should not treat methadone patients for chronic pain or for other medical problems (i.e. family practice concerns); he should ensure better practice management, e.g. assigning appointment times; he should ensure his medical record-keeping is in keeping with the expectations set out in the College policy on *Medical Records*.

Dr. Pardis’ Status Pending the Hearing

The ICRC made an interim order on April 12, 2016 under section 37 of the Health Professions Procedural Code, pending resolution of the allegations against him, Dr. Pardis was required, among other things, to practise under the guidance of a clinical supervisor acceptable to the College in his family medicine practice. On April 15, 2016, Dr. Pardis’ counsel advised that, as Dr. Pardis did not expect to be able to find a clinical supervisor for his family practice, he would cease practising family medicine as of April 24, 2016. Dr. Pardis has not practised family medicine since that date.

Dr. Pardis entered into an interim undertaking regarding his methadone practice pending resolution of the allegations against him. Among other things, Dr. Pardis agreed to practise under the guidance of a clinical supervisor acceptable to the College in respect of his methadone practice. Dr. Pardis practised under the guidance of a clinical supervisor in respect of his methadone practice pending the hearing. The clinical supervisor’s reports have been positive.

Dr. Pardis’ Undertaking

Dr. Pardis entered into an undertaking dated March 8, 2017, not to practise family medicine, effective immediately. He has agreed to notify each of his methadone patients in writing that he cannot act as their family physician or provide primary care, and to advise them that they should have their own family physician. Dr. Pardis has undertaken to maintain a record of this communication in each patient’s chart and to note in the patient’s chart whether he or she has a family physician and, if so, who that is, and to communicate relevant information to each patient’s family physician.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar to place the following terms, conditions and limitations, effective immediately, on Dr. Pardis’ certificate of registration:

Clinical Supervision

(a) Dr. Pardis shall retain a clinical supervisor, approved by the College, who will sign an undertaking in the form attached hereto as Appendix "A" (the "Clinical Supervisor"), to be returned to the College in executed form no later than seven (7) days after the date of this Order. Dr. Pardis shall practise with respect to his methadone practice under the guidance of the Clinical Supervisor for a period of three (3) months, during which time the Clinical Supervisor will at minimum review at least ten (10) of Dr. Pardis' patient charts from his methadone practice once every month, to be selected independently by the Clinical Supervisor. Dr. Pardis shall meet with the Clinical Supervisor at least once every month at his Practice Location or another location approved by the College to discuss any concerns related to patient care and/or arising from the Clinical Supervisor's chart review. Dr. Pardis shall cooperate fully with the Clinical Supervisor and shall abide by the recommendations of the Clinical Supervisor, including, but not limited to, any recommended practice improvements and ongoing professional development.

(b) If a person who has given an undertaking in Appendix "A" to this Order is unable or unwilling to continue to fulfil its provisions, Dr. Pardis shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

(c) If Dr. Pardis is unable to obtain a Clinical Supervisor on the provisions set out under paragraphs 3(a) and/or (b) above, Dr. Pardis shall cease practising medicine until such time as he has obtained a Clinical Supervisor acceptable to the College. If he is required to cease practising medicine as a result of the application of this term of this Order, this requirement shall constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the College's public register.

Reassessment

(d) Within approximately six (6) months after the completion of the period of Clinical Supervision referred to above in paragraph 3(a), Dr. Pardis will submit to a reassessment of his methadone practice (the "First Reassessment") by an assessor or assessors selected by the College (the "Assessor(s)"). The Reassessment may include a chart review, direct observation of Dr. Pardis' care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The First Reassessment shall be at Dr. Pardis' expense and he shall co-operate fully with all elements of the First Reassessment. Dr. Pardis shall abide by all recommendations made by the Assessor(s) subject to paragraph (f) below, and the results of the First Reassessment will be reported to the College and may form the basis of further action by the College.

(e) Within approximately twelve (12) months after the completion of the process of the First Reassessment, Dr. Pardis will submit to a further reassessment of his methadone practice (the "Second Reassessment") by an assessor or assessors selected by the College (the "Assessor(s)"). The Second Reassessment may include a chart review, direct observation of Dr. Pardis'

care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The Second Reassessment shall be at Dr. Pardis' expense and he shall co-operate fully with all elements of the Second Reassessment. Dr. Pardis shall abide by all recommendations made by the Assessor(s) subject to paragraph (f) below, and the results of the Second Reassessment will be reported to the College and may form the basis of further action by the College.

(f) If after either the First or Second Reassessment, Dr. Pardis is of the view that any of the Assessor(s)'s recommendations are unreasonable, he will have fifteen (15) days following his receipt of the recommendations within which to provide the College with his submissions in this regard. The Inquiries Complaints and Reports ("ICR") Committee will consider those submissions and make a determination regarding whether the recommendations are reasonable, and that decision will be provided to Dr. Pardis. Following that decision, Dr. Pardis will abide by those recommendations of the Assessor(s) that the ICR Committee has determined are reasonable. Any recommendations of the Assessor(s) which are terms, conditions or limitations on Dr. Pardis' practice and any recommendations of the Assessor(s) which the ICR Committee has identified in its decision(s) referenced in this term of this Order shall be terms, conditions or limitations on Dr. Pardis' practice, to be included on the College's public register.

Other

(g) Dr. Pardis shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within seven (7) days of this Order, and shall inform the College of any and all new Practice Locations within seven (7) days of commencing practice at that location, until the report of the assessment of his practice have been reported to the College.

(h) Dr. Pardis shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and and to any other activity the College deems necessary in order to monitor his compliance with the provisions of this Order.

(i) Dr. Pardis shall give his irrevocable consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with this Order.

(j) Dr. Pardis shall give his irrevocable consent to the College to provide the following information to all Clinical Supervisors and/or Assessors:

a. Any information the College has that led to the circumstances of this Order;
b. Any information arising from any investigation into, or assessment of, Dr. Pardis' practice;
c. Any information arising from the monitoring of his compliance with this Order or of any Undertaking to the College into which he has entered.

(k) Dr. Pardis shall give his irrevocable consent to all Clinical Supervisors and Assessors to disclose to the College and to one another any information:

a. Relevant to this Order or to any Undertaking to the College into which he has entered, including but not limited to his compliance with the same;
b. Relevant to the provisions of the Clinical Supervisor's undertaking set out at Appendix "A" to this Order;
c. Relevant to the First or Second Reassessment; and/or
d. Which comes to their attention in the course of their duties under this Order and which they reasonably believe indicates a potential risk of harm to his patients.

(l) Dr. Pardis shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Pardis appear before the panel to be reprimanded.
- Dr. Pardis pay to the College costs in the amount of $5,500.00, within 30 days of the date of this Order.

4. Dr. G.W. Powell

Name:	Dr. Gerald Powell
Practice:	Psychiatry
Practice Location:	Ottawa
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	January 10, 2017
Written Decision Date:	February 23, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **withdrawn**

Summary

<u>Psychotherapeutic Frame, Documentation and Medication Monitoring</u>

Dr. Powell is a psychiatrist practising in Ottawa. In 2009, following a complaint from a former patient, the College retained an expert to provide an independent opinion with respect to Dr. Powell's care of this patient. As a result of the concerns raised in this opinion, the College conducted a broader investigation into Dr. Powell's psychiatric practice under section 75(1)(a) of the Health Professions Procedural Code.

In this broad investigation, three main areas of concern with respect to Dr. Powell's care and treatment of patients were identified by an expert retained by the College. These included:

- Dr. Powell failed to maintain an appropriate psychotherapeutic frame in 19 of the 25 charts;

- Dr. Powell had lapses in his documentation, such as omitting start and stop times in 11 of the 25 charts and failing to document the monitoring (by himself or a family doctor) of metabolic side effects from atypical antipsychotic medications in 8 of the 25 charts; and
- Dr. Powell demonstrated inadequate knowledge regarding the monitoring of atypical antipsychotic medications in at least 1 of the 25 charts.

The College expert opined, in part, about Dr. Powell's failure to recognize and maintain the psychotherapeutic frame of the physician-patient relationship, as follows: "*…most sessions lasted longer, sometimes significantly longer, than scheduled… In addition, our discussion revealed that Dr. Powell's justification for extending sessions instead of scheduling longer sessions in advance was based on a lack of knowledge and misunderstanding about psychodynamic principles as related to the frame. He indicated that scheduling a patient for a longer session would be treating them as "special." In fact, the opposite is true: extending sessions in the manner in which Dr. Powell practices is more likely to gratify a patient's sense of being special because they are repeatedly "gifted" with extra time. Dr. Powell's system of scheduling also reveals poor judgment when it comes to deciding how and when to start and stop sessions.…Appropriately managing no shows and cancellations is also part of maintaining the frame. As I learned from the interview, Dr. Powell told patients they would be held financially responsible for missing appointments and late cancellations, yet he did not hold them to that expectation. At one point he told me that when he did collect payment, he returned it because he felt bad about charging the patient. I believe this represents what is called a counter-transference enactment. Rather than working with albeit difficult and uncomfortable transference material, the issue was avoided, modelling an approach that did not reinforce responsible behaviour and dismissed problematic behaviour."*

In an addendum to his report, the College expert amended his finding with respect to Dr. Powell's lack of skill with reference to the frame regarding one patient. However, he noted two additional concerns with respect to the documentation of important clinical changes/situations and a lack of judgment in all of the 19 patient charts in which Dr. Powell failed to maintain an appropriate psychotherapeutic frame. In addition to these revisions, the College expert withdrew his concern regarding Dr. Powell's lack of knowledge of monitoring lipid levels with respect to one patient. The remainder of the opinions reached in his initial report were maintained.

<u>Inappropriate Billing Practices</u>

The College expert also opined that all 25 charts showed evidence of inappropriate billing and that Dr. Powell's billing practices did not meet the standard of practice of the profession. Concerning billing practices included:

- Billing one unit for missed appointments;
- Billing one unit for cancelled appointments (including at least one appointment that was cancelled by Dr. Powell);

- Billing one unit for telephone calls to patients and telephone prescription renewals;
- Routinely billing for long sessions. Dr. Powell's average appointment for the patients reviewed is between 80 and 110 minutes; 50 minutes is the generally accepted length for a psychiatric appointment;
- Billing special visit premium codes (A990A and A994A) when appointments were not always eligible for a premium rate. These premiums are available to a psychiatrist when he or she attends the office on an urgent basis, when they were not otherwise scheduled to attend. Dr. Powell claimed these premiums in circumstances that did not meet the required criteria; and
- Double billing for the same block of time. There are several instances where a patient was fit in or had their appointment extended on account of a cancellation and claims were submitted to OHIP for both patients.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Powell's certificate of registration for four (4) months, to commence at 11:59 p.m. on January 10, 2017.
- The Registrar impose the following as a term, condition and limitation on Dr. Powell's certificate of registration:
  (a) Prior to resuming practice after the period of suspension of his certificate of registration, Dr. Powell shall retain a College-approved clinical supervisor, who will sign an undertaking in the form attached hereto as Schedule "A" (the "Clinical Supervisor"). For a period of twelve (12) months, Dr. Powell may practice only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management, and continuing education. The period of Clinical Supervision will commence on the expiry of the period of suspension, or on the date that the Clinical Supervisor is approved, if one is not approved during the period of suspension;
  (b) If, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Powell shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule "A". If Dr. Powell fails to retain a Clinical Supervisor on the terms set out above within thirty (30) days of receiving notification that his former Clinical Supervisor is unable or unwilling to continue in that role, he shall cease practicing medicine until such time as he has obtained a Clinical Supervisor acceptable to the College. If Dr. Powell is required to cease practice as a result of this paragraph, this will constitute a term, condition and limitation on his certificate of registration and such term, condition and limitation shall be included on the public register;
  (c) Upon completion of the twelve (12) month period of Clinical Supervision, as described above, within approximately six (6) months, Dr. Powell shall undergo a re-assessment of his practice by a College-appointed assessor (the "Assessor"). This re-assessment by the Assessor will include a review of

Dr. Powell's office charts and an interview with Dr. Powell. Dr. Powell shall abide by all recommendations made by the College-appointed Assessor. The Assessor shall report the results of this re-assessment to the College;

(d) Dr. Powell shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;

(e) Dr. Powell shall consent to the sharing of information between the Clinical Supervisor, Assessor and the College as any of them deem necessary or desirable in order to fulfill their respective obligations;

(f) Dr. Powell shall consent to the monitoring of his OHIP billings and cooperate with inspections of his practice and patient charts by the Clinical Supervisor and College representatives for the purpose of monitoring and enforcing his compliance with this term of the Order. Monitoring this term shall include making enquiries of the Ministry of Health and Long-Term Care regarding Dr. Powell's billings;

(g) Dr. Powell shall co-operate with unannounced inspections of his office practice and patient charts by the College for the purpose of monitoring and enforcing his compliance with the terms of this Order and shall provide his irrevocable consent to the College to make appropriate enquiries of any person or institution who may have relevant information for the purposes of monitoring and enforcing his compliance with the terms of this Order; and

(h) Dr. Powell shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Powell shall, within three (3) months, pay a fine to the Minister of Finance in the amount of $20,000.00, and Dr. Powell shall provide proof of this payment to the Registrar of the College.
- Dr. Powell attend before the panel to be reprimanded.
- Dr. Powell pay to the College its costs of this proceeding in the amount of $5,000 within thirty (30) days from the date of this Order.

Disgraceful, Dishonourable, or Unprofessional Conduct - 5 cases

1. Dr. M. Horri

Name:	Dr. Mehdi Horri
Practice:	Family Medicine
Practice Location:	Saskatchewan
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	September 26, 2016
Penalty Decision Date:	March 24, 2017
Written Decision Date:	March 24, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

Dr. Horri, a 51-year-old family physician who practises family medicine in Saskatchewan, graduated in 1998 from the University of Tehran in Iran. He obtained a certificate of Independent Practice in 2015.

Patient A was 23 years old when she became a patient of a family doctor, Dr. X, who diagnosed her with depression with suicidal ideation. Dr. X prescribed antidepressants to Patient A. During her third and final visit, Dr. X diagnosed Patient A with insomnia second to depression and found that Patient A did not presently have suicidal or homicidal thought process, prescribing her a different anti-depressant and sleep medicine. Following this appointment, Dr. X began a maternity leave. Patient A agreed to continue to attend for appointments with Dr. Horri, who was acting as a substitute during Dr. X's leave.

<u>Doctor-Patient Relationship</u>

Dr. Horri saw Patient A between January and June 2010, continuing the care plan commenced by Dr. X and providing Patient A with on-going support and medication management.

Patient A describes that, because Dr. Horri was a medical professional whom she would not have to see again, she disclosed personal information to Dr. Horri that she had not previously disclosed to anyone. Dr. Horri provided Patient A with support for ongoing personal challenges, depression, anxiety, and sleep difficulties. Dr. Horri renewed prescriptions to Patient A for anti-depressants and sleep medicine.

During their appointments, Patient A recollects that when she would share with Dr. Horri details of her familial challenges, Dr. Horri would tell her that he could relate to what she was experiencing given his own experiences with his family of origin.

Post-Termination Sexual Relationship

Patient A's final appointment with Dr. Horri in June 2010 was the termination of their doctor-patient relationship. Following that appointment, Patient A dropped off a thank you note for Dr. Horri at his office.

Dr. Horri looked up Patient A's phone number in her medical. He called her to thank her for the card, to offer his ongoing friendship, and to suggest that Patient A call him if she needed a friend.

Patient A describes that at his point in her life, she was fairly isolated from her support network.

Dr. Horri and Patient A developed a friendship over the subsequent weeks. They met on a few occasions for coffee or walks together.

Approximately two weeks after Patient A's last appointment with Dr. Horri, Dr. Horri visited Patient A's apartment. After watching a movie together, they had sexual intercourse.

Patient A describes that she was scared and upset because they did not use a condom and she was worried about pregnancy. Dr. Horri left $200 on Patient A's nightstand, which Patient A found highly insulting. Dr. Horri intended this as a supportive gesture. Dr. Horri left shortly thereafter for Thunder Bay where he entered the Family Practice anaesthesia program at the Northern Ontario Medical School.

After his departure, Dr. Horri and Patient A continued an on-and-off long-distance intimate relationship for about three years. Patient A travelled to see Dr. Horri and Dr. Horri would sometimes travel to see Patient A. During and after the end of the sexual relationship, Dr. Horri provided Patient A with gifts, including two $2,000 e-transfers, a credit card in her name, and a laptop.

Dr. Horri and Patient A remained in contact after the sexual relationship ended until the spring of 2014.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Horri's certificate of registration, effective immediately;
- Dr. Horri appear before the Committee to be reprimanded and the fact of the reprimand shall be recorded on the Register;

- Dr. Horri pay to the College costs in the amount of $10,000 within 30 days of the date of this Order.

Appeal

On April 6, 2017, Dr. Horri appealed the decision of the Discipline Committee to the Superior Court of Justice (Divisional Court). Pursuant to s. 25(1) of the *Statutory Powers Procedure Act*, the appeal operates to stay the decision of the Discipline Committee pending the outcome of the appeal.

2. Dr. C. Pinto

Name:	Dr. Christopher Pinto
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	December 19, 2016
Written Decision Date:	February 9, 2017

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Pinto practises family medicine in Toronto, Ontario.

On April 23, 2014, the College's Inquiries, Complaints and Reports Committee ("ICRC") considered a complaint that claimed that Dr. Pinto failed to administer his office practice in an appropriate manner by failing to provide a patient's medical records to the Workers Safety Insurance Board ("WSIB") when requested by both the WSIB and the complainant. The ICRC disposed of this complaint by requiring Dr. Pinto to attend the College to be cautioned and to require him to undertake a specified continuing education and remediation program (a "SCERP").

The ICRC identified the following concerns when it considered the complaint:

- Dr. Pinto's response to the complaint was that he was unable to find the requested records. Dr. Pinto is required to maintain an adult patient's chart for 10 years from the date of the last entry into the record. He therefore ought to have had the records available when they were requested of him in 2008;
- Dr. Pinto maintained he could not find the records. This is unacceptable, as it is a physician's responsibility to maintain records safely. If Dr. Pinto could not find the file, as he claimed, he should have told this to his patient and the WSIB in a timely fashion;

- Dr. Pinto's response to the WSIB requests for timely information was dismissive, and may have had a deleterious effect on his patient's welfare.

The SCERP ordered requires Dr. Pinto to engage a preceptor acceptable to the College to complete the SCERP, and to:

- engage in focused educational sessions with a preceptor acceptable to the College in the topic of office practice and management.
- maintain a log of requests for documentation throughout the preceptorship, noting all request details, dates of requests and responses to the requests.
- undergo a reassessment which will consist of a review of office practice and management approximately six months following the completion of the preceptorship.

Dr. Pinto appealed the decision to the Health Professions Appeal and Review Board ("HPARB"), which confirmed the ICRC's decision.

After the HPARB released its decision on June 2, 2015, the College's Compliance Case Manager requested that Dr. Pinto propose the name of a preceptor for College approval so that Dr. Pinto could engage in the educational sessions ordered by the ICRC. Dr. Pinto proposed potential preceptors on June 22, and then on August 7 and August 12, 2015, who were either unacceptable to the College or unwilling to perform the task requested.

The Compliance Case Manager wrote to Dr. Pinto, through his counsel, on August 27, 2015 requesting that Dr. Pinto follow-up with a potential proposed preceptor. Dr. Pinto, through his counsel, indicated he would follow up. The Compliance Case Manager heard nothing further regarding this preceptor.
The Compliance Case Manager wrote to Dr. Pinto, through his counsel, on September 14 and September 23, 2015 requesting an update. The College received no response for some time.

On November 10, 2015, Dr. Pinto, through his counsel, was advised that if he did not provide the name of a preceptor by November 18, 2015, the Compliance Case Manager would bring this matter to the attention of the ICRC to consider his non-compliance with the SCERP.

On November 16, 2015, Dr. Pinto proposed another preceptor. However, the proposed preceptor had not been approached by Dr. Pinto and ultimately did not agree to act as preceptor.

When the ICRC considered Dr. Pinto's failure to comply with the SCERP on February 10, 2016, Dr. Pinto had still not obtained a preceptor by that time. The ICRC referred allegations of professional misconduct to the Discipline Committee.

Dr. Pinto did not propose an additional preceptor until March 17, 2016, after allegations of professional misconduct were referred to the Discipline Committee. The College finally received an executed undertaking from an acceptable preceptor on April 25, 2016, almost one year after HPARB confirmed the ICRC's SCERP.

Dr. Pinto's preceptor provided a report to the College on August 15, 2016 and noted that Dr. Pinto has failed to maintain a log of requests for documentation (noting all request details, dates of requests and responses to the requests) as required in the ICRC's Order, referred to in paragraph 5 above. Dr. Pinto had begun to create an electronic log, but it was not complete and did not contain the required information.

Disposition

The Discipline Committee ordered and directed that:
- Dr. Pinto appear before the panel to be reprimanded.
- Dr. Pinto pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date this Order.

3. Dr. T.G. Remillard

Name:	Dr. Timothy Gordon Remillard
Practice:	Family Medicine
Practice Location:	Thornbury
Hearing:	Uncontested Facts and Joint Submission on Penalty
Decision Date:	February 27, 2017
Written Decision Date:	March 13, 2017

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

At all material times, Dr. Remillard practised family medicine in a family health group (the "Group") in a clinic in Thornbury, Ontario. The Group was composed of a number of physicians, including Dr. Remillard and Dr. X. The Group shared an electronic medical records system ("EMR"). The medical records of all patients of the Group were maintained in the EMR.

In the period preceding the events at issue in this hearing, the relationship between Dr. Remillard and Dr. X had become acrimonious, with each physician accusing the other of various types of misbehaviour. In the context of the deteriorating relationship between the two physicians, Dr. Remillard engaged in the following acts in 2014:

In transferring patient charts from the Group EMR to Dr. X, for patients who were orphaned or had been patients of Dr. Remillard or other physicians in the Group, but were now patients of Dr. X, Dr. Remillard deleted his entries from the patients' electronic charts, including family histories, diagnoses, diagnostic results, letters, forms and documents. The record deletion was not in accordance with proper document retention practices and policies.

After the deletions were discovered and brought to his attention, Dr. Remillard indicates that he restored the information to the EMR that he had previously deleted.

Disposition

The Discipline Committee ordered and directed that:
- The Registrar suspend Dr. Remillard's Certificate of Registration for a three (3) month period, effective immediately.
- The Registrar impose the following term, condition and limitation on Dr. Remillard's certificate of registration:
    - At his own expense, Dr. Remillard 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. Remillard.
- Dr. Remillard appear before the panel to be reprimanded.
- Dr. Remillard 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. A.W. Taylor

Name:	Dr. Andrew Winston Taylor
Practice:	Ophthalmology
Practice Location:	Niagara Falls
Hearing:	Contested
Finding / Written Decision Date:	July 29, 2016
Penalty / Written Decision Date:	April 24, 2017

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

The Discipline Committee found that Dr. Taylor billed for medical procedures that were not performed and instructing members of his staff to create, alter, or otherwise manipulate medical records related to such procedures.

Dr. Taylor, an ophthalmologist, operated a laser eye surgery clinic in Niagara Falls which offered at least two types of laser eye surgery – Planoscan and Zyoptix. The Zyoptix procedure was the newer, more intricate procedure and required more resources. The Zyoptix procedure was more expensive than the Planoscan procedure.

Dr. Taylor first performed the Zyoptix procedure at the clinic in the summer of 2002. From the summer of 2002 until May 2003 (the "Material Time"), over 120 patients were billed for the Zyoptix procedure when in fact they had received the less expensive Planoscan procedure. The clinic issued refund cheques to 133 patients in 2003.

The Committee found that the overbilling was deliberate and intentional and that Dr. Taylor altered or directed the altering of records to make it look as if they had received the Zyoptix, rather than the Planoscan, procedure. The Committee found that Dr. Taylor directed others to carry out blank firings of the laser (meaning no patient was present but the laser was operated), on numerous occasions in April and May 2003 to support inappropriate billing.

Dr. Taylor billed for medical procedures not performed

The Committee found that Dr. Taylor deliberately billed for medical procedures that were not performed. Specifically, the Committee finds that he billed for the more expensive Zyoptix procedure when he had actually performed the less expensive Planoscan procedure.

The Committee did not believe Dr. Taylor's testimony that he told every patient, including the more than 120 patients who were charged for the wrong procedure, that they received a different and cheaper procedure than that initially recommended by the optometrist and paid for. The Committee found it utterly inconceivable that this number of patients would have left the laser clinic without asking for their refund, or follow up sometime afterwards, if Dr. Taylor, or any other member of the clinical team, had so informed them; or, if the optometrist had discussed with them the price difference between the Zyoptix and Planoscan procedures.

In the Committee's view, an informed patient would have inquired prior to leaving the clinic, or sometime afterwards, about the anticipated refund. The Committee found that these more than 120 patients were not informed about the cost differential between the Zyoptix and Planoscan procedures and the possibility of a refund.

Dr. Taylor's assertion that the failure to refund was due to a communications gap between clinic staff was not plausible. If the failure to refund was the result of a communications gap between the operating room and the administrative office, there would have been no reason for the patient charts to be contemporaneously altered by cutting and pasting and blank firings, as discussed later in these reasons.

In April 2003, an office manager learned about rumours of a police investigation into overcharging patients from a former scrub-and-flow person who had worked in the laser clinic until the end of 2002.

The Committee found that Dr. Taylor's reaction to the rumoured police investigation was striking because he did not seek any information from the police about the investigation. He did not even attempt to confirm whether in fact there was an investigation. Instead, Dr. Taylor sought the advice of a trusted friend with communications expertise while instructing his staff to conduct a chart and financial review.

The Committee found that the extraordinary assistance of Dr. Taylor's trusted friend would not have been needed if Dr. Taylor genuinely believed that the overbilling was a mere administrative error. Dr. Taylor's friend's expert advice yielded a letter to patients accompanying the refund that was misleading. The letter stated, "A routine fiscal audit of all our patient records has indicated that, notwithstanding preoperative tests, when the final examination in the operating room occurred, one of the planned processes was deemed to be unessential. Regrettably this change was not reflected in our charge to you." The Committee found that the refund letter accompanying refunds was a deliberate attempt by Dr. Taylor to deceive patients about the reason for the refund. The Committee was troubled by the evasive and untruthful content of the letter. In no way could the reason for these refunds be described as "a routine fiscal audit of all of our patient records." Nothing in Dr. Taylor's testimony indicated anything "routine" about the rumoured police investigation that allegedly brought the matter to Dr. Taylor's attention. Furthermore, not all of the patient records were audited.

The Committee believed the office manager's testimony that she had tried unsuccessfully in the past to have Dr. Taylor cease the overbilling despite the fact she was unable to recall details of her attempts. The Committee found that the rumoured police investigation was the reason Dr. Taylor finally heeded the office manager's advice and stopped overbilling his patients.

Two staff members testified that Dr. Taylor had specifically told them not to refund any 2003 patients during the first round of refunds that were dated April 30, 2003.

The Committee found that Dr. Taylor deliberately ordered his employees in April 2003 not to refund patients who had been converted from Zyoptix to Planoscan between January and April 2003. Furthermore, the Committee found that Dr. Taylor directed his two employees to not tell the truth to his corporate partners in 2005 about the lack of refunds for converted patients between January and April 2003.

Dr. Taylor directed the alteration of records

The charts of patients, who had agreed to the Zyoptix procedure but were subsequently converted to the Planoscan procedure, were improperly altered to make it appear as if the patients had received the Zyoptix procedure when in fact they had received the less-expensive Planoscan procedure.

The Committee found that Dr. Taylor directed his staff to alter patient charts using a cut-and-paste method to make it appear as if the more expensive procedure had been performed.

Dr. Taylor was the only party to derive financial gain from withholding the patient refunds for the difference in cost between the procedures.

Conversely, had the chart alterations been instigated by the laser technicians who worked for Dr. Taylor, those technicians would have risked severe repercussions had the deceit been discovered by Dr. Taylor.

In addition, the Committee noted that the laser technicians who altered the charts did not derive any personal financial benefit from the overbilling. Indeed, the cutting and pasting only added extra time to their already long surgical day.

Cutting and pasting took place after each busy surgical day whenever Zyoptix-to-Planoscan conversions occurred. The altered medical records were vital to covering up the deliberate overbilling. The vast majority of patients during the Material Time were from the United States. These altered records would have been especially necessary for patients whose follow-up was to be co-managed by a different physician who was closer to where the patient lived.

After rumours of a police investigation into overbilling began to circulate at the laser clinic in April 2003, it is not contested that some charts were altered using a second method. The laser was “blank fired” (meaning no patient was present and the laser was operated) on numerous occasions in April and May 2003. The “blank fired” false records included patient information and the original date of surgery. These records conveyed the false impression that the more expensive surgery had been performed instead of the less expensive procedure.

Dr. Taylor did not contest that blank firings occurred. However, Dr. Taylor denied that he participated in the blank firings and/or that he instructed the staff to carry them out. The matters of who gave the instructions to conduct blank firings and who was involved in carrying them out were in dispute.

The Committee found that Dr. Taylor directed the blank firings of the laser in April and May 2003 and thus contributed to the alteration of patient charts for the purpose of covering up the over-billing. The Committee found that Dr. Taylor did order and was aware of the blank firings at the Material Time.

The Committee found that:

- Patients were over-billed for procedures that were not performed.
- Over 120 of these patients left the laser clinic after their procedure completely unaware that they were entitled to a refund.
- The charts of these patients were altered at the time of the procedure.

- These two activities – chart alteration and over-billing – were integrally linked.

The Committee concluded that both the over-billing and the chart alteration were deliberate, and, when considered together, could not have been the result of a communications gap or an administrative error.

The Committee found that Dr. Taylor's role was critical. Evidence points to his role in instructing a small number of staff to cut and paste the charts. Dr. Taylor's testimony that every patient was aware of the difference in costs between the promised Zyoptix and the delivered Planoscan was simply not credible since each of those patients left the clinic without asking for their substantial refund. The Committee also found that the letter accompanying the eventual refunds was not truthful.

There was no evidence of any motive for the laser technicians and the clinic manager to allegedly create a scheme of chart alteration and over-billing, when the people involved would have had to risk their employment and potential criminal charges without any tangible financial benefit to themselves.

Disposition

The Discipline Committee ordered and directed that:
- The Registrar revoke Dr. Taylor's certificate of registration effective immediately;
- Dr. Taylor appear before the panel to be reprimanded within three months of this Order becoming final; and
- Dr. Taylor pay costs to the College in the amount of $54,560 within six months of this Order becoming final.

Appeal

On August 26, 2016, Dr. Taylor appealed the decision of the Discipline Committee to the Divisional Court of the Superior Court of Justice. Pursuant to s. 25(1) *of the Statutory Powers Procedure Act*, the appeal operates as a stay in the matter. Therefore, the Certificate of Registration in the Province of Ontario issued in the name of Dr. Andrew Winston Taylor remains in effect pending the disposition of the appeal.

5. Dr. R. Yaghini

Name:	Dr. Reza Yaghini
Practice:	Family Medicine
Practice Location:	Thornbury
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	February 13, 2017
Written Decision Date:	April 5, 2017

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Yaghini is a family doctor who currently provides locum services to emergency departments in various hospitals in Ontario.

At the relevant time, Dr. Yaghini practised in association with a group of physicians in a Family Health Group (the "Group"), in Thornbury, Ontario. The Group was composed of a number of physicians, including Dr. X and Dr. Yaghini. At the relevant time, Dr. Yaghini also had privileges at the Grey Bruce Health Services, ("the hospital"). Dr. Yaghini had access to the hospital's electronic medical records system ("EMR"). Personal medical records pertaining to Dr. X were stored in the hospital's EMR.
In the period preceding the events at issue in this hearing, the personal and professional relationship between Dr. X and Dr. Yaghini had deteriorated and become very poor. On September 17, 2014, the Chief of Staff of the hospital contacted the College to advise that the hospital had determined that Dr. Yaghini had accessed Dr. X's personal health records through the hospital's EMR, on June 9, 2013. The access by Dr. Yaghini was in breach of the hospital's policy on access to personal health information. Dr. Yaghini was not authorized to view Dr. X's personal health records. Dr. Yaghini acknowledged that he had no justification for viewing the personal health records of Dr. X. Effective November 29, 2014, Dr. Yaghini agreed to voluntarily resign his privileges at the hospital at the request of the Chief of Staff.

Dr. Yaghini's explanation for viewing the personal health records of Dr. X is that, in the context of their deteriorating relationship, Dr. Yaghini accessed the record because of his perception of ongoing bullying and harassing behaviour by Dr. X towards him. This perception caused Dr. Yaghini to be concerned about his well-being and to question whether Dr. X might have a health issue that was motivating Dr. X's behaviour towards him. For this reason, Dr. Yaghini decided to access Dr. X's personal health records. On January 29, 2015, Dr. Yaghini completed a course titled, "Patient confidentiality and disclosing information".

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Yaghini's Certificate of Registration for a three (3) month period effective April 2, 2017 at midnight (12:00 a.m.).
- The Registrar to impose the following term, condition and limitation on Dr.
- Yaghini's certificate of registration:
    (i) At his own expense, Dr. Yaghini 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. Yaghini.

- Dr. Yaghini appear before the panel to be reprimanded.
- Dr. Yaghini 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.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2017

TOPIC: OMA Request for Member Self Reporting of CPD Compliance to the CPSO

FOR INFORMATION

ISSUE:

The OMA has asked that the College allow a number of physicians to report their Continuing Professional Development (CPD) compliance to the College and that the College consider the feasibility of assessing that compliance on an individual basis. The Executive Committee is recommending that this request be denied.

BACKGROUND:

- The CPD requirement came into effect in regulation in 2010. This requires all physicians to be a member of the two national educational bodies or an approved third pathway to allow for the tracking and reporting of their CPD.

- In 2013 the Medical Psychotherapy Association Canada (MDPAC) formerly known as the General Practice Psychotherapy Association (GPPA) was approved by Council as a third pathway organization.

- MDPAC (formerly GPPA) was able to demonstrate that they met the foundational requirements of the College. This included that any system of CPD tracking have educational requirements comparable to the RCPSC and/or the CFPC and that there be an audit function of the reporting.

- In 2012 the OMA also applied for the status of a third pathway tracking organization. As a result of a thorough review of the application the Education Committee declined the request for the following reason:

  Upon review of the application submitted, the Education Committee noted that many of the criteria approved by Council were not met. For example, question five of the application seeks an understanding of the system to define and assign credits and a formal evaluation mechanism of this system. For both parts of this question you indicate "there is no intention to develop an accreditation program" and that "The educational outcomes of specific CPD events will not be tracked". It is the

expectation that these two activities take place for applying organizations. Again, in question six you indicate that you will not be offering a CPD program but merely tracking credits issued by the CFPC or RCPSC. Also Council's criteria are that a rigorous audit system with follow-up with members who are not compliant be in place. Your application does not address these items as reflected in questions seven and eight. It is clear that the OMA application describes a program that intends to merely offer a tracking service and not a full system of CPD oversight.

CURRENT STATUS:

- It has been the role of the Education Committee to review and consider requests related to CPD tracking such as the current one from the OMA. The Education Committee met on March 10, 2017 and reviewed the request of the OMA and suggested that this request not be supported and that this recommendation be sent to the Executive Committee for consideration.

- The Executive Committee considered the recommendation of the Education Committee at its April 2017 meeting and supported the recommendation of the Education Committee that states that the request by the OMA to allow for self-reporting of physician's CPD directly to the College be denied.

- The College received the request from the OMA on January 12, 2017 (Appendix A) to reconsider alternative CPD reporting options for the estimated 2,700 physicians who are not members of the RCPSC or the CFPC.

- The letter acknowledges that the OMA is unlikely to become a recognized CPD tracking organization but instead requests the option of physician self reporting to the CPSO.

- This proposal is a different request than the one in 2012, however it does not align with the role that the College had intended to define for itself with respect to the implementation of this regulatory requirement.

- Upon a review of some of the historical documents and discussions on the implementation of the CPD requirements here at the College it was clear that the College did not want to be directly involved in the system of CPD tracking or approval. For example, a 2008 briefing note to College Council clearly states this intention when it reads "The CPSO did not want to be in a position of evaluating external education systems declared by physicians."

- The 2008 position remains relevant as the College is not currently in a position to oversee the self-reporting of physician's CPD. In order to do this we would require additional resources including, staff and an IT infrastructure to capture and assess the data reported to us. This would represent a significant undertaking.

- One of the suggestions made in the current request to the CPSO is that the tracking requirements "impose a further financial impediment" to the 2700 members. However any system developed by the College would also result in a direct cost recovery charge to these members for this additional service.

- Such a program, if developed by the CPSO, would need to meet the same bar as expected of the CFPC, RCPSC and any third pathway organization and would therefore require many months of work; vast resources and would be relevant only for a declining number of physicians.

- Approximate fees to join the RCPSC, CFPC or MDPAC as affiliates to track CPD are as follows:
    - RCPSC $630 - MOC Program info for Health Care Professionals (April 1, 2017 – March 31, 2018)
    - CFPC: $613 - Non-Member Mainpro+ Participant fee is per year (for 2016-2017)
    - MDPAC: $275 - Clinical CPSO/CPD (October 1, 2016 – September 30, 2017)

- If the College were to have to develop a CPD program it is likely that it would cost close to, if not on par, with the two national bodies.

- Based on the original intention of the College's role with respect to the CPD regulation it would therefore not seem appropriate or feasible for the College to act in the role requested in the OMA letter.

- A letter will be sent under from the president with the College's decision to deny this request.

DECISION FOR COUNCIL:

This is for information only.

Contact: Wade Hillier, Ext. 636

Date: May 10, 2017

Appendices: Appendix A – January 12, 2017 OMA Request Letter

APPENDIX A

OMA
ONTARIO MEDICAL ASSOCIATION

January 12, 2017

Dr. David Rouselle
President
College of Physicians & Surgeons of Ontario Medical Association
80 College Street
Toronto, Ontario M5G 2E2
Email: drouselle@cpso.on.ca

Dear Dr. Rouselle:

Re: Continuing Professional Development Reporting Requirements

I am writing today to request that the College of Physicians and Surgeons of Ontario (CPSO) reconsider alternative Continuing Professional Development (CPD) reporting options for the estimated 2,700 Ontario physicians who are neither members of the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC).

As directed by Council, the OMA has actively pursued this matter on behalf of our affected colleagues since 2011, when Quality Assurance amendments removed the option of independent self-reporting. Throughout this process, the OMA has sought an alternative method for members to track CPD outside of the RCPSC and the CFPC, including our 2012 proposal and application to become a recognized CME/CPD tracking organization – which was unfortunately rejected by the CPSO

Given that the OMA is unlikely to become a recognized tracking organization, we request that the option of self-reporting be reconsidered in the context of the current fiscal reality for all physicians in Ontario.

There is a significant cost associated with tracking CPD through either College as a non-member. As well, the Ministry of Health and Long Term Care has unilaterally discontinued the Continuing Medical Education Reimbursement Program, imposing a further financial impediment upon our members. This is in addition to the ongoing across the board fee cuts to physicians.

These circumstances, coupled with a recent increase to the College of Family Physicians of Canada affiliate rate, once again highlight the need for an alternate method of reporting.

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OMA
ONTARIO MEDICAL ASSOCIATION

The OMA and our members wholeheartedly support continuing education. To promote lifelong learning, we should strive to make it accessible to all physicians in a cost-effective and practical manner.

Given that a self-reporting option would accommodate a relatively small number of physicians, we would ask the CPSO to consider the feasibility of assessing compliance on an individual basis. This could ensure that every physician is meeting CPD/CME expectations, while enabling physicians to participate in a meaningful learning program without undue financial hardship.

Thank you in advance for your consideration. I am available to address any questions that you may have or to provide additional information that you may require at your convenience.

Sincerely,

Virginia M. Walley, MD FRCPC
President
Ontario Medical Association

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